No. 96-1375-CFX
Status: GRANTED

Title: Regions Hospital, Petitioner
v.
Donna E. Shalala, Secretary of Health and Human Services

Docketed:
February 27, 1997

Court: United States Court of Appeals for the Eighth Circuit

Counsel for petitioner: Sutter,Ronald N.

Counsel for respondent: Solicitor General

Entry	Date	Note	Proceedings and Orders
1	Dec 4 1996	G	Application (A96-397) to extend the time to file a petition for a writ of certiorari from December 29, 1996 to February 27, 1997, submitted to Justice Thomas.
2	Dec 5 1996		Application (A96-397) granted by Justice Thomas extending the time to file until January 28, 1997.
3	Jan 8 1997	G	Application (A96-397) to extend further the time to file a petition for a writ of certiorari from January 28, 1997 to February 27, 1997, submitted to Justice Thomas.
4	Jan 9 1997		Application (A96-397) granted by Justice Thomas extending the time to file until February 27, 1997.
5	Feb 27 1997	G	Petition for writ of certiorari filed. (Response due April 30, 1997)
7	Mar 26 1997		Order extending time to file response to petition until April 30, 1997.
8	Apr 30 1997		Brief of respondent Donna Shalala, Secretary, Health and Human Services filed.
9	May 13 1997		DISTRIBUTED. May 29, 1997 (Page 1)
10	Jun 2 1997		Petition GRANTED. SET FOR ARGUMENT December 1, 1997. **********
12	Jun 10 1997		Order extending time to file brief of petitioner on the merits until July 25, 1997.
13	Jul 25 1997		Joint appendix filed.
14	Jul 25 1997		Brief of petitioner St. Paul-Ramsey Medical Center, Inc. filed.
16	Aug 14 1997		Order extending time to file brief of respondent on the merits until September 12, 1997.
17	Sep 12 1997		Brief of respondent Donna Shalala, Secretary, Health and Human Services filed.
18	Oct 15 1997		Reply brief of petitioner St. Paul-Ramsey Medical Center, Inc. filed.
19	Oct 31 1997		CIRCULATED.
20	Nov 18 1997		Record filed.
		*	Record proceedings U.S. Court of Appeals for the Eighth Circuit.
21	Nov 20 1997		Letter from the Solicitor General received and distributed.
22	Nov 21 1997		Letter from the Solicitor General, including provisions of the Medicare Hospital Manual, received and distributed.
23	Dec 1 1997		ARGUED.

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Supreme Court, U.S.
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OFFICE OF THE CLERK

No.

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a provision (42 U.S.C. § 1395ww(h)(2)(A)) in 1986 legislation establishing a new Medicare payment methodology for graduate medical education ("GME") costs, which directs the Secretary of Health and Human Services ("the Secretary") to "determine," for a hospital's 1984 cost reporting year, "the average amount [of the hospital's GME costs] recognized as reasonable under this subchapter . . . for each full-time-equivalent resident," requires the Secretary to "determine . . . the average" using the actual, final "amount recognized as reasonable under this subchapter" for 1984 or whether it authorizes the Secretary, in determining the average, to reaudit and redetermine the amount of 1984 GME costs after the reopening and record-retention periods for 1984 have expired.

PARTIES TO THE PROCEEDINGS

Petitioner is St. Paul-Ramsey Medical Center, Inc., a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner does not have a parent or any non-wholly owned subsidiaries.

Respondent is Donna E. Shalala, Secretary of the Department of Health and Human Services.

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IN THE

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OCTOBER TERM, 1996

No. ——

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
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DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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PETITION FOR A WRIT OF CERTIORARI

St. Paul-Ramsey Medical Center, Inc. respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix ("App.") at 1a-3a) is reported at 91 F.3d 57. The opinion of the district court (App. at 4a-8a) is unreported.

JURISDICTION

The court of appeals entered its judgment on July 26, 1996. App. at 1a. It denied petitioner's petition for rehearing on September 30, 1996. App. at 9a. Justice Thomas granted two extensions of time for filing a writ of certiorari in this case, the second of which (entered

January 9, 1997) extended the time to and including February 27, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395ww(h)(2)(A) provides: "The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." So that the Court may review the provision in context, substantial portions of 42 U.S.C. § 1395ww(h) are reproduced in the appendix at 10a-15a. In addition, relevant portions of the following are reproduced in the appendix at 15a-19a: 42 U.S.C. § 1395oo; 42 U.S.C. § 1395ww(a)(1)(C); 42 U.S.C. § 1395ww(b)(3)(A); 42 C.F.R. § 405.481(g) (1995); 42 C.F.R. § 405.1803(a); 42 C.F.R. § 405.1807; 42 C.F.R. § 405.1885(a); and 42 C.F.R. § 413.86(e)(1).

STATEMENT

At issue in this case is the proper construction of a provision in 1986 legislation establishing a new Medicare payment methodology for graduate medical education ("GME") costs effective for cost reporting years beginning on or after July 1, 1985. Medicare had previously reimbursed teaching hospitals the "reasonable costs" of GME services. Under the new methodology, each year Medicare reimburses teaching hospitals a percentage, based on the ratio of Medicare patient days to total patient days, of a base year (1984) amount per intern and resident (updated for inflation) times the hospital's number of interns and residents during the payment year. With respect to the base year per resident amount, the statute directs the Secretary to "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident."

The Secretary waited until September 29, 1989, three and a half years after the statute's enactment, to issue regulations. By that date, hospitals had long since received determinations of the costs recognized as reasonable for 1984 and had received payment based on those determinations. Many of these determinations (including the determination issued to petitioner) were final and no longer subject to reopening, and teaching hospitals were no longer even required to retain audit documentation for 1984. Nonetheless, the Secretary issued a regulation, commonly referred to as the "reaudit regulation," requiring reaudits of GME costs for closed base years for purposes of determining the average base year per resident amount.

Petitioner challenges the validity of the reaudit regulation. Petitioner contends that in computing "the average" required by the 1986 legislation, the Secretary must use as the numerator the actual "amount [of GME costs] recognized as reasonable" *for* 1984, not a fictitious amount divorced from the actual amount recognized as reasonable and paid to the hospital for 1984.

A. Medicare Reasonable Cost Reimbursement

In 1965, Congress enacted the Medicare program primarily to furnish health insurance for the elderly. Pub. L. No. 89-97, § 102(a). From that time until 1983, the Medicare program reimbursed participating hospitals the "reasonable cost" incurred in furnishing services to Medicare patients. *Good Samaritan Hospital v. Shalala*, 113 S. Ct. 2151, 2154 (1993).[1]

Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective

[1] The only exception was if a hospital's costs exceeded its prevailing charges, in which case it was reimbursed its charges. 42 U.S.C. § 1395f(b)(1).

payment system ("PPS") to reimburse most hospitals for inpatient *operating* costs. Pub. L. No. 98-21, § 601(e), enacting 42 U.S.C. § 1395ww(d). Congress retained the "reasonable cost" reimbursement system for certain hospital costs, including the costs of medical education. 42 U.S.C. § 1395ww(a)(4).

B. The Medicare Audit And Review Process

The Secretary has contracted Medicare audit and payment functions to organizations (usually insurance companies) known as fiscal intermediaries. 42 U.S.C. § 1395h; *Bethesda Hospital Association v. Bowen*, 485 U.S. 399, 400-01 (1988). At the close of a year, a hospital participating in the Medicare program, commonly referred to as a "provider," files a cost report with its Medicare intermediary, which audits the cost report and issues a determination of the costs recognized as reasonable in a notice of program reimbursement ("NPR"). 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. § 405.1803 (a)(1); *Bethesda Hospital Association*, 485 U.S. at 401. A provider dissatisfied with the intermediary's determination may appeal to the Provider Reimbursement Review Board ("PRRB" or "Board") and eventually file a court suit. 42 U.S.C. § 1395oo(f)(1).

The intermediary's "findings on matters at issue" in the NPR are subject to reopening for a period of three years. 42 C.F.R. § 405.1885(a). Except in cases of fraud, no intermediary determination "may be reopened after such 3-year period." *Id.* If the provider does not appeal and a reopening has not been effected within the three-year period, the intermediary's determination is "final and binding." 42 C.F.R. § 405.1807.

C. The GME Per Resident Amount Payment Methodology

In 1985, the Secretary issued a regulation which purported to freeze medical education payments for one year at 1984 levels. Under the Secretary's regulation, a hospital's medical education reimbursement for its first cost reporting year beginning on or after July 1, 1985, would have been the lower of its allowable medical education costs for that year or for its cost reporting year beginning in fiscal year 1984 (the base year). 42 C.F.R. § 405.421 (a)(2)(i) (1985); 50 Fed. Reg. 27,732 (1985). In the accompanying preamble, the Secretary made clear that the final determination of allowable base year costs for the base year itself would also be used for purposes of the freeze. 50 Fed. Reg. 27,726 (1985).

In April 1986, Congress repealed the Secretary's freeze, and adopted a new GME payment methodology (effective for cost reporting years beginning on or after July 1, 1985), based, like the Secretary's regulation, on a hospital's GME costs during fiscal year 1984. Pub. L. No. 99-272, § 9202. The statute directed the Secretary to calculate an "average" for each hospital. 42 U.S.C. § 1395ww(h)(2)(A). This was to be done by dividing the hospital's GME costs "recognized as reasonable under this subchapter" for 1984 by the hospital's number of interns and residents in 1984, to yield "the average" base year amount per resident. *Id.* For a year subject to the new methodology, Medicare pays a percentage, based on Medicare patient days to total patient days, of the base year per resident amount adjusted for inflation times the hospital's number of residents during the year.[2] 42 U.S.C. § 1395ww(h).

D. The Reaudit Regulation

On September 29, 1989, the Secretary issued regulations to implement the GME statute. 54 Fed. Reg. 40,286-321, adopting 42 C.F.R. § 413.86. By that date,

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[2] For instance, if in 1996 a hospital's adjusted base year per resident amount was $60,000, its number of residents was 10, and its Medicare patient load (*i.e.*, Medicare patient days to total patient days) was 25%, the hospital's Medicare GME payment would be $150,000 ($60,000 x 10 x 25%).

the Medicare intermediaries had long since audited, and issued NPRs for, the 1984 year which is the base year under the new GME payment system. In many cases, the NPR for 1984 had been issued more than three years earlier so that the amount of GME costs recognized as reasonable in the NPR for 1984 was final, binding, and no longer subject to reopening. *See* 42 C.F.R. § 405.1885 (a). In addition, by that date hospitals were no longer required to retain the time records necessary for an audit of 1984 GME costs. 42 C.F.R. § 405.481(g)(3) (1995).

Nonetheless, the Secretary did not instruct the intermediaries to use the 1984 GME costs already recognized as reasonable in the normal audit and review process to determine the "average" GME per resident amount. Instead, the Secretary issued the reaudit regulation, which directed the intermediaries to reaudit a hospital's 1984 year to redetermine the 1984 GME costs to be used for the GME per resident amount calculation. 42 C.F.R. § 413.86(e)(1)(ii)-(iii). The Secretary asserted that a reaudit of 1984 costs was necessary to ensure the accuracy of the per resident amount. 54 Fed. Reg. 40,300 (1989).

As a practical matter, a reaudit of 1984 costs often proved to be impossible. Under the Secretary's record-retention requirements (42 C.F.R. § 405.481(g)(3) (1995)), hospitals were required to retain physician allocation agreements and time records for a period of only four years after the close of a cost reporting year.[8] The four-year record retention period had already expired when the Secretary issued the reaudit regulation, and

[8] Physician compensation attributable to teaching activities is a major component of a hospital's GME costs. 42 C.F.R. § 413.85(g). Hospitals conducted time studies to establish the percentage of a physician's compensation attributable to various activities, including teaching and supervision of interns and residents in approved GME programs. 42 C.F.R. § 405.481(g) (1995), *removed*, 60 Fed. Reg. 63,124, 63,175 (1995).

many hospitals no longer had the necessary records, a fact ultimately acknowledged by the Secretary in a *Federal Register* notice. 55 Fed. Reg. 36,063-64 (1990).

E. Intermediary's Reaudit Of Petitioner's 1984 GME Costs

Petitioner is a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner's GME base year is its cost reporting year ending December 31, 1984. R. 1, Complaint at 12, ¶ 35; R. 4, Answer at 4, ¶ 35. After a full audit, the Medicare intermediary issued the NPR for petitioner's 1984 fiscal year on February 28, 1986. *Id.*

Three years passed after issuance of petitioner's NPR for 1984 without a reopening related to medical education costs. R. 1, Complaint at 12, ¶ 36; R. 4, Answer at 4, ¶ 36. Accordingly, as of March 1, 1989 (three years and one day after issuance of the NPR), the intermediary's determination was "final and binding" and no longer subject to reopening. 42 C.F.R. §§ 405.1807, 405.1885 (a). Moreover, as of January 1, 1989 (four years and one day after the close of its GME base year), petitioner was no longer even required to retain the physician allocation documentation supporting the GME costs recognized as reasonable in the NPR for 1984. *See* 42 C.F.R. § 405.481(g)(1), (3) (1995); R. 1, Complaint at 13, ¶ 37; R. 4, Answer at 4, ¶ 37.

The Medicare intermediary nonetheless began reauditing petitioner's 1984 year in late 1990 for purposes of the GME per resident amount methodology. R. 1, Complaint at 13, ¶ 38; R. 4, Answer at 4, ¶ 38. On February 18, 1991, the intermediary issued a notice of average per resident amount for petitioner's 1984 year. *Id.* The intermediary computed the per resident amount in that notice by using as the numerator a "reaudited" amount of 1984 GME costs which is lower than the amount recognized as reasonable in the NPR for 1984. *Id.* The Medicare intermediary has used this per resident amount—based

on the *1991* reaudit determination of 1984 GME costs, rather than the determination in the NPR for 1984—to reimburse petitioner under the per resident methodology for all cost reporting years beginning on or after July 1, 1985. The intermediary has not applied the reaudited 1984 GME cost determination directly to petitioner's 1984 year, and petitioner's GME reimbursement for that year (which was based on the NPR) remains unchanged. R. 1, Complaint at 13-14, ¶ 39; R. 4, Answer at 4, ¶ 39.

Petitioner timely appealed the intermediary's notice of average per resident amount to the PRRB. R. 1, Complaint at 14, ¶ 40; R. 4, Answer at 4, ¶ 40. Petitioner challenged the legality of the Secretary's reaudit regulation, contending that the Secretary must use the amount of GME costs actually recognized as reasonable for 1984 through the normal audit and review process (rather than the reaudit amount) to determine the average base year per resident amount under the new methodology.

The PRRB ruled that it lacks the authority to decide the validity of the reaudit regulation, thereby allowing petitioner to file a court suit challenging the validity of the regulation.[4] R. 1, Complaint at 14-15, ¶ 41; R. 4, Answer at 4, ¶ 41. Petitioner timely filed suit in the U.S. District Court for the District of Minnesota within the period allowed by the Medicare statute. R. 1, Complaint at 15, ¶ 42; R. 4, Answer at 4, ¶ 42.

F. Court Decisions

On August 8, 1995, the district court issued a short opinion upholding the validity of the reaudit regulation.

[4] The PRRB lacks the authorty to invalidate a Medicare regulation. It is legally required to comply with all of the Secretary's Medicare regulations. 42 C.F.R. § 405.1867; *Bethesda Hospital Association*, 485 U.S. at 406. Accordingly, the Medicare statute establishes a procedure under which providers may seek judicial review of any question which the PRRB determines it lacks the authority to decide. 42 U.S.C. § 1395oo(f)(1); R. 1, Complaint at 7-8, ¶¶ 21-23; R. 4, Answer at 3, ¶¶ 21-23.

App. at 4a-8a. The court relied on the reasoning in *Administrators of the Tulane Educational Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994) ["*Tulane*"], and *The Toledo Hospital v. Shalala*, No. 3:94CV7080 (N.D. Oh. 1995), a decision that recently has been reversed by the U.S. Court of Appeals for the Sixth Circuit. *Id.* at 7a-8a.

On July 26, 1996, the U.S. Court of Appeals for the Eighth Circuit affirmed in a brief *per curiam* opinion. App. at 1a-3a. The court concluded that the reaudit regulation "must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*." *Id.* at 3a. The court noted that "it would have been far preferable had the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements. . . ." *Id.* However, the court concluded that the statute is "ambiguous" and that the Secretary's regulation represents a reasonable measure to ensure the accuracy of per resident amounts. *Id.*

REASONS FOR GRANTING THE PETITION

I. THE COURT OF APPEALS' CONSTRUCTION OF 42 U.S.C. § 1395ww(h)(2)(A) CONFLICTS WITH THE SIXTH CIRCUIT'S CONSTRUCTION.

The D.C. Circuit in *Tulane* and the Eighth Circuit in this case upheld the validity of the Secretary's reaudit regulation, finding the regulation consistent with 42 U.S.C. § 1395ww(h)(2)(A). More recently, however, the Sixth Circuit has reached a contrary conclusion in *The Toledo Hospital v. Shalala*, No. 95-3858 (Jan. 13, 1997), App. at 20a-37a. The Sixth Circuit invalidated the Secretary's reaudit regulation, concluding that the regulation conflicts with 42 U.S.C. § 1395ww(h)(2)(A). Thus, there is a direct conflict between the decision in this case and the decision of the Sixth Circuit in *Toledo*. More specifi-

cally, as addressed below, there is a direct conflict between the two decisions on three fundamental points: (1) the proper application of the principles of construction established in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); (2) whether 42 U.S.C. § 1395ww(h)(2)(A) is ambiguous; and (3) assuming that 42 U.S.C. § 1395ww(h)(2)(A) is ambiguous, whether the reaudit regulation represents a reasonable construction of the statute.

A. All three courts agreed that the validity of the reaudit regulation should be assessed under the familiar two-step analysis in *Chevron*.[6] However, the courts had significantly different understandings of *Chevron*. In *Tulane* (whose reasoning was adopted by the Eighth Circuit), the D.C. Circuit found ambiguity because the statute does not expressly address and prohibit a reaudit after the expiration of reopening and record-retention periods. In *Toledo*, the Sixth Circuit rejected this approach to *Chevron* deference, stating:

> With due respect to our sister courts, we believe that the approach taken by the court in *Tulane* misperceives the policy underlying *Chevron* deference. *Chevron* instructs courts to accept a reasonable administrative interpretation of a statute where Congress has delegated decisional autonomy to an agency. When Congress intentionally leaves gaps and ambiguous terms in a statute for the agency to flesh out, the principle of separation of powers counsels that this legislative delegation be respected by the judiciary. It is an entirely different matter, however, to presume a delegation of interstitial rulemaking authority when the claimed ambiguity in the statute stems not from the use of a word with several plausible interpretations, nor from the statute's lack of

[6] The relevant question under the first step is whether Congress' intent is clear. 467 U.S. at 842-43. If so, Congress' intent must prevail. If not, the relevant question under the second step is whether the agency's construction is reasonable. *Id.* at 843.

> specificity regarding mundane procedural issues, but from nothing more than the failure of Congress to proscribe explicitly an unusual procedure which may be plainly at odds with the result Congress was trying to reach.

App. at 29a. The Sixth Circuit concluded that "under *Chevron* analysis, a regulation does not survive the first step merely because there is a metaphysical possibility that the statute could be read in the manner advocated by the agency." *Id.* at 34a.

B. The Sixth Circuit also disagreed that 42 U.S.C. § 1395ww(h)(2)(A) is ambiguous. App. at 29a-34a. It faulted the District of Columbia and the Eighth Circuits for failing to give proper consideration to the word "average," a word which the Sixth Circuit viewed as "critical to understanding congressional intent." *Id.* at 29a-30a. Congress was undoubtedly aware of the normal administrative process for establishing final payment determinations and the normal three year reopening period, which was not even close to expiring for 1984 cost reporting years when the GME statute was enacted. *Id.* at 30a-31a. Thus, reasoned the Sixth Circuit, Congress must have expected the Secretary to use the costs determined through the normal administrative process to calculate the "average" GME costs per resident for 1984. *Id.* In the court's view, the GME statute is "not at all complex" but "merely directs the Secretary to divide one number by another." *Id.* at 31a-32a. Nothing in the statute authorizes the Secretary to redetermine the numerator used to compute the "average." *Id.* at 32a-33a.

The court found additional support for its conclusion in the traditional presumption of issue preclusion. *Id.* at 33a. Absent a contrary expression of congressional intent, parties should not be required to "reestablish or relitigate factual matters that have already been determined with finality." *Id.* It was clear to the court that

the Secretary had "strayed from the path intended by Congress" and that the reaudit regulation therefore flunks *Chevron* Step One. *Id.* at 34a.

C. Even assuming arguendo an ambiguity in the statute, the Sixth Circuit also disagreed with the District of Columbia and Eighth Circuits that the Secretary's construction could survive scrutiny under *Chevron* Step Two. *Id.* at 34a-37a. The Sixth Circuit rejected the Secretary's claim that a reaudit was necessary to ensure accuracy in the per resident amounts. The court found that the reaudit regulation was unreasonable and unfair because (1) Congress expected the cost determinations made directly for 1984 to be right, (2) providers should not be required to "reestablish the costs that they already proved years ago," particularly at a time when they were no longer required to retain supporting audit documentation, and (3) the alleged need to audit closed years, if it existed at all, arose solely because of the Secretary's inexcusable dilatoriness. *Id.* In the court's view, the "predicament was of the Secretary's making and it is unreasonable to expect the Hospital to answer for it." *Id.* at 37a.

II. THE DECISION OF THE COURT OF APPEALS IS ERRONEOUS.

A. The Secretary's Reaudit Regulation Violates the Plain Meaning And Clear Intent Of 42 U.S.C. § 1395ww(h)(2)(A).

1. The statute directs the Secretary to determine an "average." She does this by dividing (A) the "amount recognized as reasonable under this subchapter" for a hospital's 1984 cost reporting year by (B) the hospital's number of full-time-equivalent residents for that period.

The meaning of the words "amount recognized as reasonable under this subchapter" is clear. The referenced "subchapter" is subchapter XVIII of the Social Security Act, which "subchapter" is often referred to as the Medicare statute. Subchapter XVIII contains a long-established process for determining the amount of Medicare payment recognized as reasonable for *each* hospital for *each* year. *See Bethesda Hospital Association*, 485 U.S. 399 (1988); *Hospital Association of Rhode Island v. Secretary of HHS*, 820 F.2d 533 (1st Cir. 1987); *HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615 (D.C. Cir. 1994). It directs the Medicare intermediary to make a "final determination" as to each hospital's payment entitlement for each cost reporting year. 42 U.S.C. § 1395oo(a). A hospital dissatisfied with this determination has 180 days to appeal to the PRRB. 42 U.S.C. § 1395oo(f)(1). The intermediary may reopen the determination within a three-year period. 42 C.F.R. § 405.1885(a). Once that period expires, the determination is "final and binding." 42 C.F.R. § 405.1807. Thus, the statutory phrase "amount recognized as reasonable under this subchapter" for 1984 clearly refers to the amount established in the NPR upon completion of the normal audit and review process.

The *Tulane* court focused on the word "determine," suggesting that "determine" is an "activist" word that is reasonably construed as authorizing the Secretary to conduct a special reaudit of 1984 GME costs. 987 F.2d at 796 n.6. But for purposes of establishing an "average," "determine" is no more "activist" than "compute" or "calculate." *Directing the Secretary to "determine" an "average" by dividing (A) by (B) does not authorize the Secretary to "redetermine" (A).*

As part of the base year audit, the Secretary determined the amount of GME costs "recognized as reasonable." However, she did not, in the base year audit, determine the number of residents, nor did she determine the *average* amount "recognized as reasonable" *per resident*. Thus, to implement the new payment methodology, the Secretary needed to determine the number of residents and do a mathematical calculation not done for

the base year audit, *i.e.*, divide the GME costs "recognized as reasonable" in the base year audit by the number of interns and residents to produce the *average* base year per resident amount. But the determination of this "average" in no way required, or allowed, the Secretary to "redetermine" the numerator. As the Sixth Circuit correctly observed, Congress' sole directive in 42 U.S.C. § 1395ww(h)(2)(A) was for the Secretary to "determine . . . the average." App. at 29a-33a. Thus, the reaudit regulation does what the Secretary lacks the authority to do.

2. Throughout the GME legislation, Congress was careful to confer express authority on the Secretary where rulemaking was required. For instance, the number of a hospital's interns and residents (the denominator in the per resident amount formula) had no bearing on GME reimbursement for 1984, and the Secretary did not have a methodology for establishing the number for purposes of GME payment. Accordingly, Congress expressly authorized the Secretary to establish rules "for the computation of the number of full-time-equivalent residents in an approved medical residency training program" and furnished copious guidance. 42 U.S.C. § 1395ww(h)(4).

No such authorization will be found with respect to the numerator. The Medicare statute and regulations long ago established the process by which the Secretary determines the amount of GME costs recognized as reasonable for each cost reporting year. If Congress had intended for the Secretary to bypass that process and create a new process, it surely would have said so. *See Director, Office of Workers' Compensation Programs v. Newport News Shipbuilding and Dry Dock Co.*, 115 S. Ct. 1278, 1288 (1995) ("The withholding of agency authority is as significant as the granting of it, and we have no right to play favorities between the two"). Congress did not do so.

3. Both the *Toledo* court and the *Tulane* district court correctly noted that had Congress intended the Secretary's

construction, it would have worded the statute quite differently. *Toledo*, App. at 33a-34a; *Methodist Hospitals of Memphis v. Sullivan*, 799 F. Supp. 1210, 1218 (D.D.C. 1992). If the Secretary's construction were correct, the statute would say something like this:

> The Secretary shall redetermine, for purposes of this section, the amount of the hospital's allowable direct graduate medical education costs for the hospital's cost reporting period that began during fiscal year 1984, and, based on that redetermined amount, the Secretary shall determine the hospital's average amount of allowable direct graduate medical education costs for each full-time-equivalent resident for such year.

Instead, the statute directs the Secretary to use as the numerator the "amount" of a hospital's GME costs "recognized as reasonable under this subchapter" for 1984. A greater disparity between the language that Congress should have used if it had intended the Secretary's construction and the actual language employed is hard to imagine

4. The Secretary's reading of the statutory language is inconsistent with her own, and the courts', treatment of identical language in the Medicare statute. The phrase "costs . . . recognized . . . under this subchapter" appears in other statutory provisions that use base year cost data to determine Medicare reimbursements. *See* 42 U.S.C. §§ 1395ww(a)(1)(C) and 1395ww(b)(3)(A)(i). In these contexts, the Secretary has consistently "recognized" those base year costs that have been adopted as part of a final cost determination under 42 C.F.R. § 405.1807. In the one instance when the Secretary attempted to disturb final base year cost determinations, the courts blocked this effort as contrary to the statute. *Georgetown Univ. Hosp. v. Bowen*, 862 F.2d 323, 327 (D.C. Cir. 1988). The Secretary's construction of 42 U.S.C. § 1395ww(h)(2)(A) thus conflicts with the "normal

rule of statutory construction that identical words used in different parts of the same act are intended to have the same meaning." *Sullivan v. Stroop*, 496 U.S. 478, 484 (1990) (construing other chapters of the Social Security Act) (internal quotations omitted).

B. Even Assuming Arguendo An Ambiguity In The Statutory Language, The Reaudit Regulation Adopts A Patently Unreasonable Construction.

1. The *Tulane* court held that the reaudit regulation is reasonable because of the importance of ensuring the accuracy of the base year amount. This rationale does not bear analysis. The original determinations were *audited* figures. The original audits were performed shortly after the 1984 year, when audit documentation was still readily available, when memories were still fresh, and when hospital and intermediary personnel had not substantially turned over. There is no evidence of inaccuracy in those determinations. The *Tulane* court simply accepted on faith the Secretary's conclusory allegations that the 1991 reaudits were likely to be more accurate than the 1986 audits.

But even more fundamentally, a "plain meaning" construction of the statute would not have prevented the Secretary from correcting any errors that might have existed. When the GME statute was enacted, the amount recognized as reasonable for 1984 was still subject to reopening. Thus, as the *Tulane* district court correctly observed, "[a]ny concern the Secretary might have had about the accuracy of those figures could have been addressed within the standard three-year period time." *Methodist Hospitals of Memphis*, 799 F. Supp. at 1218.

2. The Medicare reopening standards apply "with respect to findings on matters at issue" in a determination. 42 C.F.R. § 405.1885(a). The "matters at issue" for which intermediaries made "findings" in the NPRs issued for 1984 in early 1986 were the allowability of a hospital's

1984 GME costs. Those were also the "matters at issue" for which intermediaries made new "findings" in the 1991 reaudits. Since those new "findings" of 1984 costs were made after the three-year reopening period had expired, they obviously conflicted with the Secretary's reopening standards. It matters not whether the Secretary applied those "findings" of 1984 costs directly to a hospital's 1984 year or to the hospital's 1990 year under the per resident amount methodology.

The reaudit regulation also conflicts with principles of res judicata and collateral estoppel. When an issue has been resolved for one year, principles of res judicata and collateral estoppel make that decision binding for subsequent years involving the same issue. *Tait v. Western Maryland Railway Co.*, 289 U.S. 620 (1933); *United States v. Moser*, 266 U.S. 236 (1924). Res judicata and collateral estoppel apply to final administrative determinations so long as there was "an adequate opportunity to litigate" the issue in the original determination, as there clearly was here. *United States v. Utah Construction & Mining Co.*, 384 U.S. 394, 422 (1966); *Draper v. Sullivan*, 899 F.2d 1127, 1130-31 (11th Cir. 1990). It is irrational to assume that Congress intended the Secretary to retroactively revoke her own reopening standards and ignore settled principles of res judicata and collateral estoppel. Only the clearest and most direct statutory command could possibly justify such a result.

3. Rationalizing the reaudits as necessary to ensure accuracy fails to take into account the purposes of a statute of limitations, of which the Medicare reopening standards are the functional equivalent. *See Pellham Bay General Hospital v. Schweiker*, [1984-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 33,468 at 9360 & n.9 (D.D.C. 1983). In *Board of Regents of the University of the State of New York v. Tomanio*, 446 U.S. 478, 487 (1980), this Court described those purposes as follows:

> Statutes of limitations are not simply technicalities. . . . [T]here comes a point at which the delay of a plaintiff in asserting a claim is sufficiently likely either to impair the accuracy of the fact-finding process or to upset settled expectations that a substantive claim will be barred without respect to whether it is meritorious.

Elsewhere, the Court has stated:

> Statutes of limitations, which are "found and approved in all systems of enlightened jurisprudence," represent a pervasive legislative judgment that it is unjust to fail to put the adversary on notice to defend within a specified period of time and that "the right to be free of stale claims in time comes to prevail over the right to prosecute them." These enactments are statutes of repose; . . . they protect defendants and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise.

United States v. Kubrick, 444 U.S. 111, 117 (1979) (citations omitted).

The Medicare reopening standards were intended to ensure, not impede, accuracy. The reaudit regulation allows exactly what the reopening standards were designed to prevent—the impairment of the "accuracy of the fact-finding process" and the "unjust" treatment of hospitals that had already been put on notice that the determination of 1984 costs was "final and binding." It defies belief that a 1991 audit of a 1984 cost reporting year, conducted two years after that year was closed under long-established Medicare principles, will yield more accurate results than did the 1986 audit of the 1984 reporting year.

4. When the GME statute was enacted, the amounts recognized as reasonable for 1984 were not final and

remained subject to reopening. Under these circumstances, Congress obviously did not intend that the Secretary make two separate determinations of allowable GME costs under "reasonable cost" principles for the same period of time. An agency may not rationally apply the same principles to the same provider for the same period of time (1984) to reach two equally valid but different determinations of allowable costs. *See Methodist Hospitals of Memphis*, 799 F. Supp. at 1218. If the first determination is final and valid (as the Secretary concedes it is), the later, inconsistent determination must necessarily be invalid. *See, e.g., American Federation of Government Employees, AFL-CIO, Local 3090 v. FLRA*, 777 F.2d 751, 760 (D.C. Cir. 1985) (Scalia, J., concurring) ("I do not think it to be true . . . that an agency is free to take inconsistent positions. . . . It is the agency's responsibility to behave in a rational (and hence reasonably consistent) fashion").

The Secretary's construction is premised on the absurd proposition that Congress intended to allow the Secretary to wait until 1991 (five years after the enactment of the GME statute), when 1984 years were closed and hospitals were no longer required to retain key supporting documentation, to reaudit 1984 costs for purposes of a methodology that applies to hospital cost reporting years beginning in 1985. Nor does the absurdity of the Secretary's position end there. If the Medicare finality rules do not apply, then there are no time constraints on the Secretary. If the Secretary was entitled to reaudit 1984 costs in 1991, nothing prevents her from reauditing 1984 costs again in 1998 or 2001 if she decides that there may have been some problem with the 1991 reaudit. The logic of the Secretary's position would potentially subject hospitals to an endless series of reaudits of 1984 costs.

C. The Secretary's Reaudit Regulation Is Impermissibly Retroactive.

Absent express statutory authority, the Secretary lacks the authority to issue a retroactive rule. *Bowen v. George-*

town University Hospital, 488 U.S. 204 (1988). The Secretary's reaudit regulation is impermissibly retroactive in several respects.

1. The reaudit regulation is obviously retroactive for the period July 1, 1985, through October 30, 1989—a period of almost four and a half years. The Secretary's regulations were issued on September 29, 1989, with an October 30, 1989 effective date. 54 Fed. Reg. 40,286 (1989). However, the Secretary is applying the regulation to all cost reporting periods beginning on or after July 1, 1985.

2. The reaudit regulation imposes a significant new burden with respect to petitioner's 1984 year. It subjects the 1984 cost reporting year to a reaudit that was no longer permissible under the Medicare subchapter.

The Secretary's contention that her construction simply uses antecedent facts for prospective purposes is patently false. The Secretary's construction upsets hospitals' vested rights with respect to "final and binding" determinations applicable to antecedent facts. 42 C.F.R. §§ 405.1807, 405.1885(a). The effect of the reaudit regulation was to retroactively revoke the reopening and record-retention standards applicable to 1984, *after* the reopening and record-retention periods for 1984 had already expired. *Id.*; 42 C.F.R. § 405.481(g)(1) (1995). Consequently, hospitals were forced to reestablish costs that had been proven with finality long ago.

In *Landgraf v. USI Film Products*, 114 S. Ct. 1483, 1505 (1994), this Court stated that, in assessing retroactivity, courts should be guided by "familiar considerations of fair notice, reasonable reliance, and settled expectations. . . ." 114 S. Ct. at 1499. The GME statute does not provide any sort of "notice," fair or otherwise, that 1984 costs would be subject to reaudit after the Medicare reopening period. Indeed, nothing in the statute suggests that hospitals' "reasonable reliance" and "settled expectations" with respect to the finality of the 1984 cost determinations may be upset.

In *Landgraf*, the Court strongly endorsed "the 'uniformly' accepted rule against 'giv[ing] to statutes a retrospective operation, whereby rights previously vested are injuriously affected, unless compelled to do so by language so clear and positive as to leave no room to doubt that such was the intention of the legislature.'" 114 S. Ct. at 1500 (citation omitted). By the date that the Secretary issued the reaudit regulation, petitioner's rights with respect to the finality of the 1984 cost determination had "vested" (*i.e.*, the determination was final and no longer subject to reopening), and those rights were subsequently "injuriously affected" by the Secretary's reaudit. Accordingly, since the GME statute obviously does not include "language so clear and positive as to leave no room to doubt" that Congress intended the Secretary to inflict this retroactive injury to vested finality rights, the reaudit regulation clearly constitutes an impermissible retroactive construction of the statutory language.[6]

3. In issuing the reaudit regulation, the Secretary retroactively revoked core principles underlying the Medicare PPS for operating costs. Ever since their promulgation in 1983, the Secretary's PPS regulations have specified that the hospital-specific rate is "final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983" except in very limited circumstances not encompassed by the GME reaudit. 42 C.F.R. § 405.474(b)(1)(v) (1983), 42 C.F.R. § 412.71(d) (1996). Moreover, the Secretary's regulations also specified that the characterization of costs (*i.e.*, operating or medical education) used to establish the PPS hospital-specific rate must also be used for future years. 42 C.F.R. § 405.477(c)(2) (1983), 42 C.F.R. § 412.113(b) (1987). As part of the reaudit regulation,

[6] Assuming that *Chevron* were applicable, petitioner agrees with the Sixth Circuit's application of *Chevron* in *Toledo*. However, because of the retroactive nature of the reaudit regulation, petitioner contends that *Landgraf*, not *Chevron*, furnishes the correct standard of review in this case.

the Secretary retroactively revoked both the "consistency rule" and the finality of the PPS hospital-specific rate. *See* 42 C.F.R. § 412.113(b)(3); 42 C.F.R. § 413.86(e)(1)(ii)(B)-(C); 42 C.F.R. § 413.86(j).

In so doing, the Secretary candidly acknowledged in the *Federal Register* preamble to the GME regulations: "There is nothing in section 1886(h) of the [Social Security] Act [42 U.S.C. § 1395ww(h)] that addresses the recomputation of HSRs [hospital-specific rates]." 54 Fed. Reg. 40,301 (column 1) (1989). Thus, the Secretary by her own admission does not possess the express grant of statutory authority necessary under *Georgetown* to retroactively amend the PPS hospital-specific rates—an adjustment that is a necessary by-product of the GME reaudit regulation.

III. THE QUESTION PRESENTED IS IMPORTANT.

The question presented is important for several reasons.

A. At issue is the proper construction of a major federal statute of immense importance in all States of the Union and the District of Columbia. The statute directly and substantially affects the proper amount of Medicare reimbursement for the nation's teaching hospitals. It implicates not only the hospitals' financial well-being, but also has a significant bearing on the quality of the graduate medical education that they are able to furnish.

B. This case involves fundamental principles of administrative fairness. As the Sixth Circuit noted, the underlying question is whether courts should, in the absence of Congressional authorization, "permit administrative agencies to require a party to reestablish or relitigate factual matters that have already been determined with finality." App. at 33a. The Sixth Circuit's answer was that the Secretary may not require providers "to reestablish the costs that they already proved years ago." *Id.* at 36a. The Sixth Circuit properly concluded:

> The Secretary ignored the principle of collateral estoppel and the basic fairness issues implicated. Finally, the Secretary ordered the reaudits to occur only after the providers had been permitted to dispose of the records necessary to allow for a meaningful audit.

Id. at 37a. Administrative agencies need to understand that they cannot disavow final and binding agency determinations upon which parties have justifiably long relied.

C. This case involves important issues regarding the proper principles for reviewing agency constructions of federal statutes. Although both the Sixth Circuit and the Eighth Circuit purported to apply *Chevron*, they had very different understandings of the proper role of the Judiciary in applying *Chevron*, thus demonstrating the need for clarification by this Court. Moreover, the Secretary's revocation in 1989 of the reopening and record-retention standards applicable to 1984, *after* the reopening and record-retention periods for 1984 had already expired for many hospitals (including petitioner), raises important issues under the Court's decisions in *Georgetown* and *Landgraf*. For all these reasons, further review is warranted.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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February 1997

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 95-3477

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Plaintiff-Appellant,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Defendant-Appellee.

Appeal from the United States District Court
for the District of Minnesota

Submitted: June 14, 1996

Filed: July 26, 1996

Before LOKEN, ROSS, and HANSEN, Circuit Judges.

PER CURIAM.

Under the Medicare program, a teaching hospital's graduate education ("GME") costs are reimbursable or "allowable" costs. A 1986 statute changed the reimbursement methodology. To establish a base year for the new methodology, Congress directed the Secretary of Health and Human Services to "determine, for the hosptial's cost reporting period that began during fiscal year 1984, the

average amount recognized as reasonable under this subchapter . . . for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). By the time the Secretary promulgated regulations implementing this directive in 1989, the three-year reopening period for finally determining 1984 GME costs under the prior regime had expired for most hospitals. The Secretary's regulations nonetheless authorize reauditing a hospital's 1984 base year GME costs so as to exclude "nonallowable or misclassified costs." 42 C.F.R. § 413.86(e)(l)(ii)(B); *see* 53 Fed. Reg. 36,589, 36,591-92 (1988).

As a result of this reaudit process, St. Paul-Ramsey Medical Center's base-year allowable GME costs were reduced from $9,892,644 to $5,494,955. Because the 1984 reimbursement year is closed, St. Paul-Ramsey need not refund any 1984 reimbursements because of this reaudit. But St. Paul-Ramsey has been and will be adversely affected in subsequent years as a result of having its base year GME costs significantly reduced for purposes of applying the new reimbursement methodology. Therefore, like other adversely affected teaching hospitals around the country, St. Paul-Ramsey commenced this lawsuit, arguing not that *its* reaudit was flawed, but that the Secretary's reaudit regulations are invalid. The attack proceeds on three fronts—the regulations contravene the plain meaning of the statutory phrase, "recognized as reasonable under this subchapter"; alternatively, if the statute is ambiguous, the Secretary's interpretation is "patently unreasonable"; finally, the regulations violate the presumption against retroactivity.

These contentions were thoroughly considered and rejected by the District of Columbia Circuit in *Administrators of Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994). *Accord The Toledo Hosp. v. Shalala*, No. 3:94cv7080 (N.D. Ohio June 23, 1995), *appeal pending*, No. 95-3858 (6th Cir.). After carefully considering the parties'

briefs and arguments and the legislative history of these complex statutes and regulations, we agree with the district court [1] that the Secretary's reaudit regulations must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*. The statute is ambiguous, and the reaudit regulations are not an exercise in retroactive rulemaking. While it would have been far preferable had the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements, the substance of the regulations is clearly reasonable. As the court said in *Tulane*, 987 F.2d at 797, "The agency's belief that Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursements to health care providers can hardly be deemed unreasonable or inconsistent with the congressional purpose of erecting a new and more accurate reimbursement methodology."

The judgment of the district court is affirmed.

A true copy.

Attest:

Clerk, U.S. Court of Appeals, Eighth Circuit.

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[1] The HONORABLE RICHARD H. KYLE, United States District Judge for the District of Minnesota.

APPENDIX B

[Filed Aug. 8, ~~1995~~]

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Civil No. 3-94-1522

ST. PAUL RAMSEY MEDICAL CENTER, INC.,
Plaintiff,

vs.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Defendant.

MEMORANDUM OPINION AND ORDER

Introduction

Plaintiff commenced this action challenging Medicare regulations issued by the Department of Health and Human Services ("HHS" or "agency") pursuant to 42 U.S.C. § 1395ww(h)(2)(a) which implement a new methodology for reimbursing graduate medical education costs incurred by teaching hospitals. This matter is currently before the Court on the parties' cross motions for summary judgment. The Court will grant the Defendants Motion and uphold the agency's regulations.

Background [1]

Congress established the Medicare program, 42 U.S.C. §§ 1395 *et seq.*, to provide health insurance to the elderly and disabled. Part A of this program provides insurance for covered inpatient and related post-hospital services. Under Medicare regulations, a hospital may be reimbursed for the costs of certain educational programs for health care professional trainees, including programs for interns and residents known as graduate medical education ("GME") programs. 42 C.F.R. 413.85(a). Until 1985, participating hospitals were reimbursed for costs incurred in furnishing GME services based on the "reasonable cost . . . actually incurred." 42 U.S.C. § 1395x (v)(1)(A).

In April, 1986, Congress enacted legislation establishing a new GME cost reimbursement system. *See* Pub. L. No. 99-272, 100 Stat. 153-155 *et seq.*, 42 U.S.C. § 1395ww(h). The statute provided that:

> The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospitals for each full-time-equivalent resident.

Id. The HHS was directed to calculate a per-resident amount for each hospital by dividing the amount of GME costs recognized as reasonable for the base period of 1984 (numerator) by the number of full-time equivalent interns and residents working at the hospital in 1984 (denominator). To determine a hospital's GME reimbursement in future years, the 1984 base period per-resident

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[1] The statutory and regulatory background surrounding the pertinent issue in this case is more fully set forth in *Administrators of the Tulane Educ. Fund. v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994) and *Toledo Hosp. v. Secretary of Health and Human Serv.*, No. 3:94cv7080, (N.D. Ohio, June 23, 1995).

amount, adjusted for inflation, would be multiplied by the number of full-time-equivalent residents during the year in question, and that product would be multiplied by the hospital's Medicare patient load in that same year. 42 U.S.C. § 1395ww(h)(3).

On September 29, 1989, HHS promulgated final regulations ("reauditing regulation(s)") implementing the new GME reimbursement rules established in the 1986 statute. *See* 54 Fed. Reg. 40,286, codified at 42 C.F.R. § 413.86. By the time this regulation was issued, however, most hospitals had already been reimbursed for 1984 GME costs. Nevertheless, the regulations directed Medicare fiscal intermediaries (usually insurance companies) to reexamine or "verify" GME costs from the base year (1984) and to conduct a reaudit of the costs allowed for the base year if the claimed base year appeared to include "misclassified or nonallowable costs," or if the costs for the base year appeared "unreasonably high." 54 Fed. Reg. at 36,591.

The Plaintiff in this case claims this "reauditing" procedure is invalid. The Plaintiff claims that the terms "average amount recognized as reasonable under this subchapter" in 42 U.S.C. § 1395ww(h)(2)(A) refer specifically to the amount which had been derived from the standard cost reporting and review process following the close of the 1984 fiscal year. As a result, Plaintiff contends that a recalculation of this figure is not permissible and that the reaudit regulation contained in 42 C.F.R. § 413.86 is therefore invalid.

This Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

Discussion

Plaintiff has made the following arguments in support of its challenge to the HHS's reauditing regulation:

(1) The reauditing regulation is not entitled to the traditional deference afforded to agency regulations under the standard set forth in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) because the language of 42 U.S.C. § 1395ww(h)(2)(A) unambiguously requires the HHS to use the figure derived from the standard cost reporting and review process following the close of the 1984 fiscal year and not a "recalculated" figure, and, as a result, the regulation is invalid;

(2) The reauditing regulation is invalid because it is an unreasonable interpretation of § 1395ww(h)(2)(A); and

(3) The reauditing regulation is a "retroactive rule" not specifically required under § 1395ww(h)(2)(A) and is thus invalid under *Landgraf v. USI Film Products*, 114 S. Ct. 1483 (1994) and *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988).

Plaintiff's challenge to the HHS's reaudit regulation, 42 C.F.R. § 413.86, has been considered and rejected by both the Court of Appeals for the District of Columbia and the United States District Court for the Northern District of Ohio. *See Administrators of the Tulane Educ. Fund. v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994); *Toledo Hosp. v. Secretary of Health and Human Serv.*, No. 3:94cv7080, (N.D. Ohio, June 23, 1995). *Tulane* and *Toledo Hospital* concluded: (1) the language of 42 U.S.C. § 1395ww(h)(2)(A) was ambiguous and did not require the HHS to use the figure derived from the standard cost reporting and review process following the close of the 1984 fiscal year; (2) the reauditing regulation was a reasonable interpretation of § 1395ww(h)(2)(A); and (3) the reauditing did not impose an impermissible "retroactive rule."[2] The

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[2] *Tulane* was decided prior to *Landgraf v. USI Film Products*, 114 S. Ct. 1483 (1994). However, the Court finds *Landgraf* does

Plaintiff does not distinguish *Tulane* and *Toledo Hospital*, but asserts that they were incorrectly decided. The Court has carefully reviewed the Plaintiff's arguments. The Court finds the opinions in *Tulane* and *Toledo Hospital*, although not binding, to be persuasive, thorough, well-reasoned and indistinguishable from the present case. No useful purpose would be served by a third detailed analysis of the issues presented here. The Court is satisfied with the legal analyses of the *Tulane* and *Toledo Hospital* opinions and adopts them here. There being no genuine issue of material fact, Defendant is entitled to judgment as a matter of law.

Conclusion

Accordingly, based on the foregoing, and upon all the files, records and proceedings herein, IT IS ORDERED that:

(1) Plaintiff's Motion for Summary Judgment (Doc. No. 12) is DENIED;

(2) Defendant's Motion for Summary Judgment (Doc. No. 15) is GRANTED; and

(3) Plaintiff's Complaint (Doc. No. 1) is DISMISSED WITH PREJUDICE.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: August 8, 1995

/s/ Richard H. Kyle
RICHARD H. KYLE
United States District Judge

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not affect *Tulane*'s conclusion regarding the reauditing regulation's alleged retroactive effect. The Court also notes that, in upholding the regulation, *Toledo Hospital* considered its alleged retroactivity in light of *Landgraf*. *See Toledo Hosp. v. Secretary of Health and Human Serv.*, No. 3:94cv7080, slip op. at 13-15 (N.D. Ohio, June 23, 1995).

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 95-3477MNST

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Appellant,

v.

DONNA E. SHALALA, ETC.,
Appellee.

Appeal from the United States District Court
for the District of Minnesota

ORDER

The petition for rehearing filed by the appellant has been considered by the court and is denied.

September 30, 1996

Order Entered at the Direction of the Court:

/s/ Michael E. Gaus
Clerk
U.S. Court of Appeals
Eighth Circuit

APPENDIX D

STATUTES AND REGULATIONS INVOLVED

1. 42 U.S.C. § 1395ww(h) provides in relevant part:

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B of this subchapter (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

* * * *

(E) Treatment of certain hospitals

In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) Hospital payment amount per resident

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

(C) Medicare patient load

As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A of this subchapter.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the

Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(5) Definitions and special rules

As used in this subsection:

* * * *

(F) Initial residency period

The term "initial residency period" means the period of board eligibility plus one year, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

* * * *

2. 42 U.S.C. § 1395oo provides in relevant part:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter rereferred to as the "Board") * * * if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report

* * * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received.

* * * *

Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

3. 42 U.S.C. § 1395ww(a)(1)(C) provides:

The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

4. 42 U.S.C. § 1395ww(b)(3)(A) provides:

Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable

operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

5. 42 C.F.R. § 405.481(g) (1995) provides in relevant part:

(g) *Recordkeeping requirements.* * * *, each provider that claims payment for services of physicians under this subpart must:

* * * *

(3) Retain each physician compensation allocation, and the information on which it is based, for at least four years after the end of each cost reporting period to which the allocation applies.

6. 42 C.F.R. § 405.1803(a)(1) provides:

Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

7. 42 C.F.R. § 405.1807 provides:

Effect of intermediary determination.

The determination shall be final and binding on the party or parties to such determination unless:

(a) An intermediary hearing is requested in accordance with § 405.1811 and an intermediary hearing decision rendered in accordance with § 405.1831; or

(b) The intermediary determination is revised in accordance with § 405.1885; or

(c) A Board hearing is requested in accordance with § 405.1835 and a hearing decision rendered pursuant thereto.

8. 42 C.F.R. § 405.1885(a) provides in relevant part:

A determination of an intermediary * * * may be reopened with respect to findings on matters at issue in such determination * * * by such intermediary officer * * * either on motion of such intermediary officer * * * or on the motion of the provider affected by such determination * * * to revise any matter in issue at any such proceedings. * * * any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

9. 42 C.F.R. § 413.86(e)(1) provides in relevant part:

Determining per resident amounts for the base period—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

* * * *

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

* * * *

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 95-3858

THE TOLEDO HOSPITAL,
Plaintiff-Appellant,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Defendant-Appellee.

On Appeal from the United States District Court
for the Northern District of Ohio

Decided and Filed January 13, 1997

Before: BOGGS and NORRIS, Circuit Judges; HOOD, District Judge.*

ALAN E. NORRIS, Circuit Judge. At issue in this case is the validity of the Medicare reaudit regulation, 42 C.F.R. §§ 413.86(e)(1)(ii)-(iii). For the following reasons, we conclude that the reaudit regulation is invalid under the guidelines set out by the Supreme Court in

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* The Honorable Joseph M. Hood, United States District Judge for the Eastern District of Kentucky, sitting by designation.

Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

I. Regulatory Framework

From 1965 to 1986, the Medicare program reimbursed participating hospitals, known as providers, for the reasonable costs incurred in furnishing graduate medical education ("GME"). The Secretary of Health and Human Services (the "Secretary") delegated the task of administratively determining these costs to fiscal intermediaries. The procedure for determining a provider's reasonable costs for GME involved several steps. First, providers would submit a cost report to a fiscal intermediary shortly after the end of the reporting year. *See* 42 C.F.R. § 413.24(f)(2)(i) (1995). The fiscal intermediary would then issue a notice of program reimbursement (an "NPR"). *See* 42 C.F.R. § 405.1803(a) (1995). A provider dissatisfied with the allowed costs could appeal the intermediary's determination to the Provider Reimbursement Review Board (the "Board"). *See* 42 U.S.C. § 1395*oo*(a)(1); 42 C.F.R. § 405.1835(a) (1995). Judicial review of final decisions of the Board was authorized by 42 U.S.C. § 1395*oo*(f)(1).

To aid in the audit and review of providers' claims, the Secretary required each provider to retain records pertaining to its physicians' compensation, as well as the amount of time each physician devoted to Medicare versus non-Medicare duties. 42 C.F.R. § 405.481(g)(3) (1995), *removed*, 60 Fed.Reg. 63,124, 63,175 (1995). The Secretary required that such records be retained for at least four years after the end of each cost reporting period to which the allocation applies. *Id.* To further ensure the accuracy of the audit process, the Secretary allowed for the reopening of a cost determination within three years of the last administrative action taken with respect to the year in question. *See* 42 C.F.R. § 405.1885 (a) (1995).

In April of 1986, Congress enacted the Comprehensive Omnibus Budget Reconciliation Act of 1986 (the "Act"), Pub. L. No. 99-272, 1986 U.S.C.C.A.N. (100 Stat.) 82. Among the changes adopted, the Act converted GME reimbursements from a pass-through basis to a per-resident reimbursement indexed to a base year. Section 9202(a) of that act amended § 1886 of the Social Security Act, 42 U.S.C. § 1395ww, by, among other things, enacting 42 U.S.C. § 1395ww(h)(2)(A), the current version of which reads as follows: "The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 1986 U.S.C.C.A.N. (100 Stat.) at 171-72 (the "GME amendment"). Section 9202(a) further provides that the base year per-resident average would be adjusted for inflation and used to calculate GME reimbursements for future years. *See* 42 U.S.C. §§ 1395ww(h)(2)(C)-(D) Section 9202(b) of the Act provides that the amendments in § 9202(a) "shall apply to hospital cost reporting periods beginning on or after July 1, 1985." 1986 U.S.C.C.A.N. (100 Stat.) at 175.

While the Act was passed in April of 1986, the Secretary waited until September of 1989 to adopt implementing regulations. *See* 54 Fed. Reg. 40,286, 40,316-17 (1989) (Codified at 42 C.F.R. § 413.86(e)(1)). These regulations first instruct the fiscal intermediaries to verify that the costs allowed for each provider for the base year, fiscal year 1984, are accurate and to exclude any costs improperly allowed in the initial audit. *See* 42 C.F.R. §§ 413.86(e)(1)(i)-(ii) (1995). The regulations then address GME cost determinations that are more than three years old and, therefore, are no longer subject to reopening: "If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify

the hospital's base-period costs solely for purposes of computing the per resident amount." 42 C.F.R. § 413.86 (e)(1)(iii) (1995) (together with 42 C.F.R. § 413.86 (e)(1)(ii), the "reaudit regulation"). Thus, finding that a provider's 1984 GME costs were too high would not require repayment from the provider for that year if the reaudit occurred after the end of the reopening period. Because many providers had disposed of their records for 1984 after having retained the documents for the requisite four-year period, the Secretary allowed providers who no longer had their 1984 records to submit information from subsequent years as evidence of the number of residents and the percentage of time dedicated to Medicare activities for the base year. *See* 55 Fed. Reg. 35,990, 36,063-64 (1990).

II. Facts

Plaintiff, The Toledo Hospital (the "Hospital"), uses the calendar year as its fiscal year. Accordingly, its base year for purposes of the Medicare regulations ended on December 31, 1984. On February 26, 1986, a fiscal intermediary issued the NPR for 1984, recognizing that the Hospital was entitled to $5,867,705 in reasonable GME costs. The Hospital did not appeal that finding to the Board, and the three-year reopening period for the 1984 determination ended on February 26, 1989. Under the four-year record-keeping requirement, the Hospital was required to retain its physician compensation records for 1984 until December 31, 1988.

Pursuant to the reaudit regulations adopted in September of 1989, a fiscal intermediary began a reaudit of the Hospital's base year in late 1990. On January 31, 1991, the intermediary found that the initial determination of the Hospital's base-year cost was nearly forty percent too high and that the appropriate GME costs for 1984 were $4,278,371. Based upon this adjusted cost figure and the number of full-time-equivalent residents for 1984, the intermediary determined an average per-resident GME

amount that results in substantially lower GME reimbursements to the Hospital for cost years beginning on January 1, 1986, than would have been the case if the original cost figure had been used.

The Hospital appealed the fiscal intermediary's reaudit calculation to the Board. On December 17, 1993, the Board ruled that it lacked authority to decide the validity of the Secretary's reaudit regulation, thereby allowing for immediate judicial review in the district court. *See* 42 U.S.C. § 1395*oo*(f)(1). Shortly thereafter, the Hospital filed this suit in the United States District Court for the Northern District of Ohio seeking both declaratory and injunctive relief. The Hospital argued that (1) the reaudit regulation is impermissibly retroactive, (2) the regulation conflicts with the Medicare statute, and (3) the regulation is arbitrary and capricious. On March 27, 1995, the Hospital filed a motion for summary judgment, and the Secretary filed a cross-motion for summary judgment on March 30, 1995. On June 23, 1995, the district court issued an order granting summary judgment in favor of the Secretary and denying the Hospital's summary judgment motion. The Hospital filed this appeal.

III. *Chevron* Analysis

We review the district court's grant of summary judgment de novo. *See Holiday Inns, Inc. v. 800 Reservation, Inc.*, 86 F.3d 619, 622 (6th Cir. 1996). Because the denial of the Hospital's motion for summary judgment was based entirely upon a ruling of law, rather than the presence of factual issues for trial, we review that decision de novo as well. *See Greene v. Reeves*, 80 F.3d 1101, 1104 (6th Cir. 1996). The familiar standard for assessing the validity of federal regulations appears in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.
>
> If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-43 (footnotes omitted). Moreover, "[i]f a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." *Id.* at 843 n.9.

The Hospital argues that *Chevron* does not apply in the present case because of the retroactive nature of the reaudit regulation. Although courts generally do not defer to retroactive agency regulations when the statutes that they implement do not require retroactive application, the reaudit regulation does not amount to an impermissible retroactive regulation. In *Landgraf v. USI Film Products*, 114 S. Ct. 1483 (1994), the Supreme Court defined the test for retroactivity as "whether the new provision attaches new legal consequences to events completed before its enactment." *Id.* at 1499. While the reaudit regulation does require a determination based upon events occurring in the base year, it does not change the standards under

which the base year costs are to be determined. Thus, we believe that *Chevron* applies in this case.

A. Step One: Plain Meaning

The first step in the *Chevron* analysis is to determine whether Congress has expressed an intent on the issue at hand. That intent can appear in the language of the statute, or it can become apparent in light of the statutory scheme taken as a whole. The GME amendment directs the Secretary "to determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). The Hospital contends that the plain meaning of this language prohibits the Secretary's reaudit regulation, which directs the fiscal intermediaries to recalculate the 1984 GME costs even after the three-year reopening period has expired.

Determining whether a statute is unambiguous is not always an easy matter. The first court to address the validity of the reaudit regulation, the District Court for the District of Columbia, held that the regulation contradicts the plain language of the statute. *See Methodist Hosps. v. Sullivan*, 799 F. Supp. 1210, 1216-17 (D.D.C. 1992), *rev'd sub nom. Administrators of the Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994). In reversing the district court, however, the Court of Appeals for the District of Columbia discovered ambiguity in the words "determine," "recognized as reasonable," and "under this subchapter." *Administrators of the Tulane Educ. Fund v. Shalala*, 987 F.2d 790, 794-96 & n.6 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994). The next three courts to address this issue, beginning with the district court in the case at bar, relied heavily upon the reasoning in *Tulane* and concluded that the statute is ambiguous. *See Toledo Hosp. v. Shalala*, No. 3:94CV7080, slip op. at 8-9 (N.D. Ohio June 23, 1995); *St. Paul Ramsey Medical Ctr., Inc. v. Shalala*, 1995 WL 879969, at 2 (D. Minn. Aug. 8, 1995), *aff'd*, 91 F.3d 57 (8th Cir. 1996); *St. Paul-Ramsey Medical Ctr., Inc. v. Shalala*, 91 F.3d 57 (8th Cir. 1996).

Before proceeding with our own examination of the GME amendment, we consider it worthwhile to review the approaches taken by the two courts of appeals that have had occasion to address the validity of the reaudit regulation. The Court of Appeals for the District of Columbia in *Tulane* began its analysis with the following summary:

> [W]e do not believe that Congress spoke directly to the precise question of whether HHS should, in determining the base period GME per resident amount, automatically adopt the GME sum approved for reimbursement to hospitals for 1984 or whether it retained the residual authority to reassess at a later date the reasonableness of that calculation for prospective use only. *Given this ambiguity*, we find that HHS reasonably determined that Congress would not likely have wished misclassified and nonallowable costs inadvertently reimbursed to hospitals for fiscal year 1984 to be "cemented" into the base period amount and indefinitely carried forward in the formula for future reimbursements. *To avoid that eventuality, HHS must retain the ability to revisit its 1984 reimbursements for error*, even though those figures had previously been found reasonable, since the sole purpose of the reauditing was to calculate the base period formula applicable under the 1986 statute for fiscal year 1985 and later years.

987 F.2d at 792 (emphasis added).

The court identified the crux of the matter as follows:

> The issue thus devolves into whether, assuming its knowledge of the long-standing regulation providing

> for a three year period for reopening approved costs, 42 C.F.R. § 405.1885, Congress in enacting the 1986 GME Amendments left some leeway for the eventuality that HHS might not be able to promulgate and implement regulations governing the new methodology until after that three year period had lapsed, or whether, even if the new regulations should be delayed until after the three year period, Congress clearly intended to prohibit the Secretary from reauditing the 1984 costs for past errors in order to establish an accurate base period per resident amount.

Id. at 794. The court then identified the purpose of the 1986 statute as to establish "a new and presumably more accurate methodology for reimbursing GME costs . . . ." *Id.* at 795. The court concluded that there is no evidence that Congress meant to preclude the Secretary from revisiting the 1984 cost determinations.

The court then went on to note that the statutory language is ambiguous:

> Finally, and perhaps most importantly, the relevant phrase "amount recognized as reasonable under this subchapter" is on its face ambiguous. We know only one thing for sure, that it certainly could not have included any amounts already finally approved before the statute was enacted since, in 1986, every hospital's 1984 NPR was still subject to the three year reopening period. *See* 42 C.F.R. § 405.1885. But beyond that given, it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three year reopening process. It might just as well have permitted the Secretary the option of using a figure that would be "recognized as reasonable under this title" at a later time after more careful assessment.

Id. at 796.

In a footnote, the court also considered the ambiguity of the word "determine":

> We also note that because the statute directs the HHS to "determine" the "average amount" of GME costs per FTE resident "recognized as reasonable," it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula. This activist language suggests that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations.

Id. at 796 n.6.

The Court of Appeals for the Eighth Circuit explicitly adopted the reasoning of *Tulane* in *St. Paul-Ramsey Medical Ctr., Inc. v. Shalala*, 91 F.3d 57, 58 (8th Cir. 1996).

With due respect to our sister courts, we believe that the approach taken by the court in *Tulane* misperceives the policy underlying *Chevron* deference. *Chevron* instructs courts to accept a reasonable administrative interpretation of a statute where Congress has delegated decisional autonomy to an agency. When Congress intentionally leaves gaps and ambiguous terms in a statute for the agency to flesh out, the principle of separation of powers counsels that this legislative delegation be respected by the judiciary. It is an entirely different matter, however, to presume a delegation of interstitial rulemaking authority when the claimed ambiguity in the statute stems not from the use of a word with several plausible interpretations, nor from the statute's lack of specificity regarding mundane procedural issues, but from nothing more than the failure of Congress to proscribe explicitly an unusual procedure which may be plainly at odds with the result Congress was trying to reach.

It seems to us that when the court in *Tulane* parsed the GME amendment, it failed to accord proper attention and

importance to the word "average," a term that is critical to understanding congressional intent. The GME amendment, in establishing a reimbursement scheme keyed to a base-year figure, introduced the concept of the per-resident average cost. This concept had not been used previously in the calculation of reimbursements and became the basis for all future payouts. Upon fulfilling the obligation imposed by the GME amendment, the Secretary would arrive at this number, the per-resident average, which would then be adjusted for inflation and utilized to determine future reimbursements. Given the introduction of this entirely new cost concept, we do not believe that the *Tulane* court was warranted in seizing upon the word "determine" as "activist language" that would authorize agency action that goes far beyond a simple calculation of the per-resident average based upon 1984 figures arrived at through the normal administrative process. *See Tulane*, 987 F.2d at 796 n.6.

We also see no ambiguity in the language "recognized as reasonable under this subchapter." While the court in *Tulane* felt that the temporal focus of this language was open-ended, thereby permitting the incorporation of substantive regulatory standards formulated at any time, including after the enactment of the GME amendment, that interpretation is strained at best. While we agree that the use of the past participle "recognized" does not restrict the Secretary to using numbers that had been finally determined prior to the passage of the GME amendment, as all of the base-year determinations were still subject to administrative reopening in 1986, there is no basis for the additional inferential leap that the Secretary was therefore free to "recognize" these costs at any time in the future and in a manner utterly detached from the established procedural framework.

When Congress passed the GME amendment in 1986, it knew that there was an administrative scheme in place that would determine the reasonable GME costs for pro-

viders for fiscal 1984. And one must assume that Congress also knew that the 1984 determinations would remain subject to reopening for over a year under the Secretary's existing regulations. It follows that Congress must have contemplated that the Secretary would use those administratively determined reasonable costs as the basis for calculating the average GME cost per full-time-equivalent resident. Indeed, it seems unlikely that Congress, having chosen for its benchmark a cost year still subject to reopening under the existing Medicare regulations, would have been contemplating anything else when it passed the amendment.

The strongest argument for ambiguity may stem from an inference that, because Congress must have understood that regulations might not be forthcoming until after the 1984 cost determinations had ceased to be subject to reopening, it intended that the Secretary would have the authority to reaudit the base-year numbers. That argument is circular, however, as it presupposes that Congress intended the GME amendment to require a reassessment of the 1984 costs. Only if the amendment would assign to the Secretary a new and substantial administrative burden would there be a congressional expectation that implementing regulations would take any real time to formulate. The Secretary argues that a three-year delay in enacting implementing regulations is understandable and foreseeable in light of the "complex statutory scheme," a phrase that seems to be invoked any time a statute occupies more than a page of the United States Code. However, the statute and its contemplated result are not at all complex. A major overhaul of the Medicare system might entitle the Secretary to consume a considerable amount of time in preparing regulations. That surely is not the case with the GME amendment, which merely directs the Secretary to divide one number by another. Moreover, if, as it seems clear to us, Congress intended the actual 1984 costs to be plugged into the per-resident average calculation, it was not attempting to create work

for the Secretary with respect to the cost determination. And it follows that, since there was no such extra work contemplated and there was no reason to suppose that promulgating regulations would consume three years, there was no reason to address in the statute the specific issue of authority to reaudit closed base years.

What the Secretary is really saying is that Congress must have contemplated that the administrative mechanism to determine reasonable GME costs, created by Congress and implemented by the Secretary's regulations, might not work as well as planned. The Secretary's argument concedes that her agents, the fiscal intermediaries, were not as diligent as they could have been when they initially audited the 1984 numbers. The rationale offered by the Secretary is that because each year's cost determination formerly had no impact beyond that year, it was not as important at that time to get the numbers exactly right. Only now, when Congress has designated a base year that will affect future reimbursements, has it become essential that the fiscal intermediaries root out errors. However, when the statutory language is read in the context of the circumstances surrounding its adoption, it is difficult to come to any conclusion other than that Congress anticipated that the administrative scheme already in place would function properly and arrive at the true reasonable GME costs for fiscal 1984 and that these numbers would then be divided by the number of residents to yield the per-resident average costs. Congress could not have foreseen the Secretary's delay in issuing the regulations and her claim that the initial 1984 cost determinations were unreliable. Otherwise, it might well have authorized the reaudit scheme, or simply have selected a different base year.

The Secretary suggests that there was no choice but to reaudit, given the delay in issuing the regulations. It would not be "reasonable" under the GME amendment, the argument runs, to use a base-year cost figure that had

since been discovered to be unreliable, so the statute required a recalculation. The answer to that argument is that the Secretary was without authority to issue the reaudit regulation. The Secretary should have either used the administratively determined 1984 figure or informed Congress of the need for further legislation.

The intent of Congress in enacting the GME amendment should also be considered in the context of the traditional presumption of issue preclusion with respect to administrative findings, since "Congress is understood to legislate against a background of common-law adjudicatory principles." *Astoria Fed. Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 108 (1991). It seems to us that, absent some indication from Congress that administrative findings were not to be given preclusive effect, courts should be hesitant to permit administrative agencies to require a party to reestablish or relitigate factual matters that have already been determined with finality. *See id.* at 107-08. We are unable to accept the Secretary's suggestion that estoppel does not apply because the incentive to determine the issue correctly did not exist during the initial audits, or was not as strong, when each year's cost determination had no effect beyond that year. *See United States v. Berman*, 884 F.2d 916, 922-23 (6th Cir. 1989). After all, the Secretary was directed by statute to determine the reasonable costs for GME, a factual question identical to the determination in the reaudit regulation and one that the Secretary was required by law to resolve. The absence of statutory language negating the presumption of issue preclusion strongly suggests that Congress intended the Secretary to use the 1984 costs derived through the ordinary administrative process.

Finally, it is difficult to imagine that, had Congress intended the result urged by the Secretary, it would have used the language that ultimately found its way into the statute. Instead, a statute focusing on reaudits possibly leading to new, reasonable cost figures, could be expected to include directions to the Secretary to "determine, for

the hospital's cost reporting period that began during fiscal year 1984, the amount recognized as reasonable under this subchapter for graduate medical education and the average cost of graduate medical education for each full-time-equivalent resident," or something similar. Surely, such a statute would not, as did the actual GME amendment, direct the Secretary to "determine" solely "the average amount." It seems apparent that the only substantive calculation contemplated by the statute is this per-resident average, and there is no basis for asserting that the 1984 figures should be reassessed outside the existing administrative scheme.

Under *Chevron* analysis, a regulation does not survive the first step merely because there is a metaphysical possibility that the statute could be read in the manner advocated by the agency. The GME amendment does not, by its terms, explicitly proscribe the reaudit that occurred in this case. Nevertheless, the statutory framework, as well as the regulations in place at the time that the GME amendment was enacted, provide clear illumination of the will of Congress. When this court can readily discern that an agency has strayed from the path intended by Congress, the inference of legislatively delegated authority vanishes. In the absence of delegated authority, *Chevron* deference is not warranted. Accordingly, we believe that the reaudit regulation is inconsistent with the legislative intent behind the GME amendment, and thus that it fails under the first prong of *Chevron*.

B. Step Two: Reasonableness

When a regulation satisfies step one of *Chevron*, the analysis shifts to a determination of whether the agency's construction of its statute is reasonable. The review for reasonableness examines whether the agency properly exercised its discretion within the sphere of its delegated authority. Review of this question centers on whether the agency action either "fills a gap" or otherwise fits within

"the legislature's revealed design." *NationsBank of North Carolina v. Variable Annuity Life Ins. Co.*, 115 S. Ct. 810, 813-14 (1995). Although we have concluded that the reaudit regulation fails at the first step of *Chevron*, we hold in the alternative that the reaudit regulation is an unreasonable interpretation of the GME amendment.

The two key considerations that led the court in *Tulane* to conclude that the reaudit regulation satisfies the second prong of *Chevron* were (1) the interest in preventing erroneous cost determinations from being perpetuated in the form of excessive future reimbursements and (2) the time needed by the Secretary to regulate within a "complex statutory scheme." *Tulane*, 987 F.2d at 797. The Secretary argues that a failure to reaudit would have been unreasonable, given the presumed intent of Congress to eliminate mistakes in the base-year calculations. The Secretary notes that the reaudits have resulted in many instances in findings of much lower base-year costs than were originally determined through the normal administrative mechanism. The Secretary also argues that it could have amended the reopening regulation to allow for a longer reassessment window. The district court in this case also stressed that the hospitals had at least some notice of the possibility of reauditing, *see* 53 Fed. Reg. 36,589, 36,591-92 (1988), and thus should have retained their physician compensation allocation records beyond the four-year period.

The Hospital responds that, because (1) the records have been disposed of, (2) many of the relevant hospital personnel have moved to other jobs, and (3) memories of what specific duties residents performed in 1984 have faded, there is no way that a reaudit would produce a more accurate assessment of 1984 costs than did the initial audits. As for the lower costs determined by the reaudits, the Hospital argues that the result necessarily follows from the absence of supporting documentation. Only those costs that could be proved were allowed in the reaudit,

and without any records the Hospital could no longer prove as much of its GME costs as it was able to do in the original audit.

The Secretary is obviously correct that Congress did not want faulty base-year calculations to be perpetuated. What the Secretary fails to recognize is that Congress expected the Secretary to get the calculations right the first time. There is no claim that the Hospital tried to deceive the fiscal intermediary by submitting a fraudulent cost report for 1984, and the regulations expressly allow for reopening at any time where fraud is shown. *See* 42 C.F.R. § 405.1885(d) (1995). The Secretary simply claims that it was swamped with work, including coping with earlier amendments to the Medicare statute, that resulted in less attention being paid to the initial cost determinations for 1984. We believe that the principle of issue preclusion prevents the Secretary from requiring providers to reestablish the costs that they already proved years ago.

The other significant problem with the Secretary's argument is that the whole reaudit issue arose because the Secretary waited three years before issuing regulations. Had the Secretary acted promptly, there would have been no need to revisit any closed determinations, because all of the 1984 numbers were still subject to reopening for some time after the passage of the GME amendment. Even after the Secretary recognized that there might be problems with the 1984 numbers and that reaudits may be necessary, there was a delay of at least a year before the reaudit regulation was enacted. *See* Fed. Reg. 36,589, 36,591-92 (1988) (indicating that errors had been made in previous audits). During that year, many, if not most, of the 1984 determinations ceased to be subject to reopening.

The bottom line is that the Secretary's response to the GME amendments has been unreasonable on all counts. The Secretary read the amendments as requiring a substantive reevaluation of the 1984 numbers. The Secretary waited far too long to issue regulations, justified solely by the nebulous assertion of statutory and regulatory complexity. While there was a brief mention in the Federal Register of the possibility of reaudits once the Secretary came to suspect that the base-year calculations may have been flawed, those comments cannot be considered notice of the need to retain physician allocation and compensation records when all that the Secretary would have had to do to mitigate the harm here was to (1) extend the reopening period, (2) extend the record-keeping period, or (3) reopen all of the 1984 determinations. The Secretary ignored the principle of collateral estoppel and the basic fairness issues implicated. Finally, the Secretary ordered the reaudits to occur only after the providers had been permitted to dispose of the records necessary to allow for a meaningful audit.

The predicament was of the Secretary's making and it is unreasonable to expect the Hospital to answer for it. Accordingly, we believe that the reaudit regulation fails step two of *Chevron*.

IV. Conclusion

The judgment of the district court, granting summary judgment to the Secretary and denying summary judgment to the Hospital, is **reversed**. The cause is **remanded** with instructions to grant summary judgment to the Hospital.

APPENDIX F

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 92-5281

ADMINISTRATORS OF THE TULANE EDUCATIONAL FUND,
d/b/a TULANE MEDICAL CENTER HOSPITAL AND CLINIC,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5282

METHODIST HOSPITALS OF MEMPHIS,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5283

GEORGE WASHINGTON UNIVERSITY HOSPITAL,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5284

LUCY WEBB HAYES NATIONAL TRAINING SCHOOL
FOR DEACONESSES AND MISSIONARIES, A CORPORATION,
Appellee

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

No. 92-5285

GREATER SOUTHEAST COMMUNITY HOSPITAL;
FAIRFAX HOSPITAL,
Appellees

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant

Argued January 19, 1993
Decided March 9, 1993

Appeal from the United States District Court
for the District of Columbia

(Civil Action Nos. 92cv01120, 92cv00009,
92cv00041, 92cv00870 and 92cv00989)

Before WALD, RUTH B. GINSBURG and D.H. GINSBURG, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* WALD.

WALD, *Circuit Judge:* The Department of Health and Human Services ("HHS" or "agency") appeals the district court's decision invalidating the agency's 1989 regulations implementing a new statutory methodology, enacted by Congress in 1986, for reimbursing teaching hospitals for the graduate medical education ("GME") costs attributable to Medicare services. Under the statute, HHS is to determine, for fiscal year 1984, the average per resident amount of GME costs "recognized as reasonable" for each hospital, and then to use this 1984 base period figure to calculate the hospital's GME reimbursements for all subsequent years. The agency interpreted this statutory directive as permitting it to reexamine and reaudit previously approved, but possibly erroneous or unreasonable, 1984 GME costs, and promulgated reauditing regulations to that effect. Appellees, a group of six hospitals which receive Medicare funds ("Hospitals"),[1] successfully brought a facial challenge to the regulations, arguing that the statutory phrase "amount recognized as reasonable" unambiguously required HHS to employ, without modification, previously approved 1984 GME cost figures, and further, that the agency's reaudit regulations were impermissibly retroactive.

We disagree with the district court that the language of the statute is so plain. Specifically, we do not believe that Congress spoke directly to the precise question of whether HHS should, in determining the base period GME per resident amount, automatically adopt the GME sum approved for reimbursement to hospitals for 1984 or whether it retained the residual authority to reassess at

[1] The appellees are Methodist Hospitals of Memphis, George Washington University Hospital, Lucy Webb Hayes National Training School for Deaconesses and Missionaries, the Administrators of the Tulane Educational Fund d/b/a Tulane Medical Center Hospital and Clinic, Greater Southeast Community Hospital, and Fairfax Hospital.

a later date the reasonableness of that calculation for prospective use only. Given this ambiguity, we find that HHS reasonably determined that Congress would not likely have wished misclassified and nonallowable costs inadvertently reimbursed to hospitals for fiscal year 1984 to be "cemented" into the base period amount and indefinitely carried forward in the formula for future reimbursements. To avoid that eventuality, HHS must retain the ability to revisit its 1984 reimbursements for error, even though those figures had previously been found reasonable, since the sole purpose of the reauditing was to calculate the base period formula applicable under the 1986 statute for fiscal year 1985 and later years. Under those circumstances, the readjustment of the 1984 figures did not constitute impermissible retroactive rulemaking. For these reasons, we reverse the district court and uphold the agency's regulations.

I. BACKGROUND

Health care providers that participate in the Medicare program are eligible to be reimbursed for medical education costs associated with an approved GME program that relate to Medicare services. Under previous HHS regulations, providers were required each fiscal year to file a "cost report," including GME costs, with a "fiscal intermediary" designated by HHS. 42 C.F.R. § 405.1801. The intermediary then determined the total amount of reimbursement due the provider in the form of a "notice of program reimbursement" ("NPR"), 42 C.F.R. § 405.1803, which could be challenged by the provider before the Provider Reimbursement Review Board ("Board"). 42 U.S.C. §§ 1395oo(a), (b); 42 C.F.R. §§ 405.1835, 405.1837. The Secretary of HHS could timely reverse, affirm or modify a Board decision. 42 U.S.C. § 1395oo(f)(1). By regulation, the Secretary also could, within three years, reexamine any determination by a fiscal intermediary, the Board or the Secretary. 42 C.F.R. § 405.1885. Finally, providers were entitled to

obtain judicial review of Board decisions and any reversal, affirmance or modification by the Secretary. 42 U.S.C. § 1395oo(f)(1).

Until 1985, hospitals were reimbursed for GME costs under a "reasonable cost" system, 42 U.S.C. § 1395f (b)(1), but in 1985, the HHS promulgated new regulations specifying that hospitals would thereafter be reimbursed for the lesser of allowable costs for the current year or the hospitals' approved costs incurred during fiscal year 1984. 50 Fed. Reg. 27,722 (1985). However, in 1986, Congress itself passed Pub. L. No. 99-272, 100 Stat. 153-155 *et seq.*, 42 U.S.C. § 1395ww(h) ("GME Amendments") which established a new methodology for calculating reimbursements for all periods beginning on or after July 1, 1985. The statute required HHS to first

> determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A). Thus, HHS was directed to calculate a per resident amount for each hospital by dividing the amount of GME costs recognized as reasonable for the base period of 1984 (numerator) by the number of full-time equivalent ("FTE") interns and residents working at the hospital in 1984 (denominator). For hospitals that had no approved medical residency training program or did not participate in Medicare in 1984, HHS was to determine the "appropriate" per resident amount. 42 U.S.C. § 1395ww(h)(2)(E). To determine a hospital's GME reimbursement for 1985 and future years, the 1984 base period per resident amount, adjusted for inflation, would be multiplied by the number of FTE residents working in the hospital during the year in question, and that product would be multiplied by the

hospital's Medicare patient load in the same year. 42 U.S.C. § 1395ww(h)(3).

By 1989, when HHS promulgated regulations to implement the 1986 GME Amendments, virtually all hospitals had already received NPRs for 1984, and in most cases, the regulatory three year reopening period had expired. Nevertheless, the new regulations permitted the fiscal intermediaries to reaudit the 1984 GME costs and "exclude[] from the base-period graduate medical education costs any nonallowable or misclassified costs," for purposes of determining the "base-period per resident amount." 42 C.F.R. § 413.86(e)(1)(ii). Acknowledging that the three year reopening period had expired for most hospitals, the Secretary stressed that the regulations "indicate[d] that if a hospital's base-period cost report is no longer subject to reopening under § 405.1185, the intermediary may modify the hospital's GME base-period costs *solely* for purposes of computing the per resident amount," and not to adjust the amount owed under the 1984 NPR. 54 Fed. Reg. 40,301 (emphasis added); *see* 42 C.F.R. §§ 413.86(e)(1)(iii). Moreover, the Secretary assured hospitals that "no new reimbursement principles will be applied during the reaudit. Rather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied." 54 Fed. Reg. 40,301 (1989). Finally, hospitals were given 180 days to appeal any determination of their base period per resident amount. 42 C.F.R. § 413.86 (e)(1)(v).

In 1990, the intermediaries began reauditing hospitals' cost reports and found that the allowable 1984 GME amount for each of the six appellee Hospitals was lower than the amount previously approved.[2] For instance, the

[2] The Hospitals complain that they were only required to retain certain records relevant to the reimbursement calculation for four years after the end of a cost reporting period, 42 C.F.R. § 405.481 (g), and therefore, at the time of reauditing, some no longer had

fiscal intermediary for Methodist Hospitals of Memphis ("Methodist") determined that Methodist's allowable 1984 GME costs were $2,785,809, $893,841 less than the $3,679,650 approved by the intermediary in an NPR issued in 1986. Because more than three years had passed since the time the NPRs became final, the reaudits did not result in any recoupment of reimbursements for 1984 but only affected the base period calculation. Methodist appealed to the Board and filed a motion for expedited judicial review on the ground that the Board lacked authority to pass on the validity of the agency's regulations. By statute, the Board has thirty days to rule on such a motion, 42 U.S.C. § 1395oo(f)(1), and when that period expired without a ruling by the Board,[3] Methodist, joined by the five other appellees, filed the present action in district court, challenging the legality of the regulations. The district court ruled for the Hospitals on summary judgment, finding the regulations invalid as contrary to the plain meaning and intent of the GME Amendments and as an unauthorized retroactive rule. *Methodist Hospitals v. Sullivan*, Civil Action Nos. 92cv01120, 92cv00009, 92cv00041, 92cv00870, 92cv00989 Memorandum Opinion ("Mem. op.") (D.D.C. July 17, 1992). The Secretary now appeals that decision.[4]

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this documentation. *See* Appellee's Brief at 9. HHS has responded by permitting the fiscal intermediaries, where necessary, to use records from later years for purposes of calculating the 1984 per resident amount. *See* 55 Fed. Reg. 36,063-64 (1990). The Hospitals do not directly challenge this practice in the present litigation, but they urge that the need to resort to this procedure is evidence of the irrationality of HHS's regulations.

[3] The Board issued an order denying expedited judicial review but did not rule on the validity of the reauditing regulations.

[4] On appeal, the HHS does not question the district court's subject matter jurisdiction. *See* Appellant's Brief at 3 n.2.

II. ANALYSIS

A. *Statutory Intent*

Under the familiar *Chevron* two-step analysis for reviewing an agency's construction of a statute, we ask first "whether Congress has directly spoken to the precise question at issue," and if not, we consider whether the agency's interpretation of the question left open by the statute is a reasonable one. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-44 (1984). Here the district court was confronted with the task of interpreting the statutory directive that HHS "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). The district court went no further than the first *Chevron* step, concluding that the statutory phrase "amount recognized as reasonable" clearly mandated that HHS use as the base for future payments the 1984 GME costs previously approved by the agency, and that "the plain meaning of the statute does not authorize a reaudit of the 1984 base year costs." Mem. op. at 15. We, however, find it necessary to proceed to the second *Chevron* station because we are not persuaded that the statutory phrase is without ambiguity in the context of the 1986 GME Amendments.

The Hospitals argue their case for nonambiguity on several fronts. First they say, and the district court held, "Congress could not have intended that the Secretary interpret 'recognized as reasonable' to mean two amounts for fiscal 1984: one derived from the standard cost reporting and review process following the close of the fiscal year; and a lower figure recalculated once the Secretary realized that the year would become the base-year for subsequent determinations." Mem. op. at 18. In the district court's view, "[i]f the figures were 'recognized as reason-

able' for the purpose of determining the costs in fiscal year 1984, they must also be recognized as reasonable for subsequent years." *Id.* at 17. The issue thus devolves into whether, assuming its knowledge of the long-standing regulation providing for a three year period for reopening approved costs, 42 C.F.R. § 405.1885, Congress in enacting the 1986 GME Amendments left some leeway for the eventuality that HHS might not be able to promulgate and implement regulations governing the new methodology until after that three year period had lapsed, or whether, even if the new regulations should be delayed until after the three year period, Congress clearly intended to prohibit the Secretary from reauditing the 1984 GME costs for past errors in order to establish an accurate base period per resident amount. The statutory text certainly does not address this administrative dilemma directly, and the Hospitals cite to no legislative history to show that Congress had any intent at all about it. HHS, predictably but persuasively, took the position in promulgating the reaudit regulation that it is "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301 (1989). Indeed, since the GME Amendments were enacted for the purpose of establishing a new and presumably more accurate methodology for reimbursing GME costs, the most natural assumption to be drawn from the statutory silence on the subject would be that Congress did not mean to preclude HHS from correcting past mistakes in the 1984 figure which would govern subsequent payments. In sum, we can find no convincing evidence, direct or indirect, that Congress meant to prohibit corrective reauditing of the 1984 GME cost figures.[5]

[5] The district court also intimated, though the Hospitals do not argue it on appeal, that the fact that Congress did not expressly delegate to the HHS rulemaking authority to determine the "amount recognized as reasonable," whereas it did so authorize the HHS to "establish rules" for computing the number of FTE residents, supports the conclusion that Congress did not intend to allow any reauditing. Mem. op. at 19 (citing 42 U.S.C. § 1395ww(h)(4)(A)). But the two situations are quite different and justify different statutory treatments. The FTE figure was an entirely new concept in the GME Amendments and required HHS to establish a procedure for its calculation. By contrast, the concept of reasonable costs already was a mainstay of Medicare statutes and regulations, *see* 42 U.S.C. § 1395x(v), 42 C.F.R. § 405.1803, and there was no need to establish any new rulemaking authority for its determination.

As a second arrow in their quiver, the Hospitals rely heavily on our decision in *Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"), which involved a statutory four year transition period beginning in 1983 for shifting from a "reasonable cost" to a "prospective payment" system for Medicare reimbursement of hospital in-patient operating costs. Under the statutory scheme, HHS was to determine reimbursement using hospital-specific rates calculated on the basis of "the allowable operating costs of in-patient hospital services . . . recognized under this subchapter for such hospital for the preceding 12-month cost reporting period." 42 U.S.C. § 1395ww(b)(3)(A). The HHS regulations, however, provided that when a hospital successfully appealed an intermediary's estimation of the 12-month base period costs to the agency or to a court, the finally approved figure would be used as the reimbursement base only in the phase-in year *following* the final decision on review. *Georgetown II*, 862 F.2d at 325. We said, however, in overturning those regulations, that by "allowable" costs Congress meant costs incurred during the reporting period that were finally determined to be allowable after all statutorily-authorized administrative and/or judicial review had been exhausted. *Id.* at 326-27; *see also Tucson Medical Ctr. v. Sullivan*, 947 F.2d 971, 976 (D.C. Cir. 1991). On a "turnabout is fair play" rationale, the Hospitals argue here that an administratively "final" determination that a hospital's 1984 GME costs were reasonable precludes any later reassessment, for any purpose, of that same year's costs.

Georgetown II, while obviously involving similar subject matter, has little bearing on the specific issues in debate here. In that case, we construed the phrase "allowable operating costs . . . recognized under this subchapter" to require HHS to apply a final administrative or judicial decision on the allowability of a particular cost retrospectively to the year under appeal. We simply did not believe that Congress intended that "preliminary estimates [of allowable costs], although administratively necessary, would somehow become final and unalterable before the review process under the statute had been completed." 862 F.2d at 327. The logic underlying our conclusion there was very different from that pressed upon us here by the Hospitals, *i.e.*, that the directive in the GME Amendments to determine the "amount recognized as reasonable" for 1984 precludes HHS from ever reauditing that cost determination *for purposes of computing a base period figure for use in succeeding years*. HHS is in no way attempting here to "effectively cement[] unlawful calculations into the transition year payments by largely insulating them from review," as it was in *Georgetown II*. 862 F.2d at 328. Just the opposite. It is attempting to ensure that misclassified and nonallowable costs approved in NPRs for 1984 are *not* cemented indefinitely into future GME cost reimbursements.

Finally, and perhaps most importantly, the relevant phrase "amount recognized as reasonable under this subchapter" *is* on its face ambiguous. We know only one thing for sure, that it certainly could not have included any amounts already finally approved before the statute was enacted since, in 1986, every hospital's 1984 NPR was still subject to the three year reopening period. *See* 42 C.F.R. § 405.1885. But beyond that given, it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three year reopening process. It might just as well have permitted the Secretary the option of using a figure that

would be "recognized as reasonable under this title" at a later time after more careful assessment. *See also Dept. of Treasury v. FLRA*, 960 F.2d 1068, 1072 (D.C. Cir. 1992) ("[The statutory phrase] 'adversely affected' is simply an adjectival phrase, not a verbial phrase indicating the past tense, and hence allows alternative temporal readings. The language, in short, is ambiguous . . . .").[6] In our own review of the statutes governing Medicare reimbursement, we have uncovered at least two other occasions in which Congress has used the phrase "recognized as reasonable." Section 1395x(v), pertaining to the manner in which HHS determines a cost to be reasonable, permits the Secretary to "provide for the establishment of limits [on certain costs] *to be* recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x (v)(1)(A) (emphasis added). Section 1395uu, concerning payments to promote the closing or converting of under-utilized hospital facilities, provides that the Secretary, in determining the hospital's proper "transitional allowance," recognize "the outstanding portion of actual debt obligations *previously* recognized as reasonable for purposes of reimbursement." 42 U.S.C. § 1395uu(c)(1)(B) (emphasis added). We refer to these sections only to suggest that the phrase "recognized as reasonable," by itself, does not tell us whether Congress means to refer the Secretary to action already taken or to give directions on actions about to be taken. Context is all, and in this case, we believe the use of the 1984 figures for the indefinite future cautions us against a reading of the phrase that

[6] We also note that because the statute directs the HHS to *"determine"* the *"average* amount" of GME costs per FTE resident "recognized as reasonable," it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula. This activist language suggests that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations.

allows no elbow room for adjustments based on prior miscalculations or errors.

Because we agree with HHS that "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843.

B. *Reasonableness*

In its proposed regulations to implement the GME Amendments, HHS reasoned that "[b]ecause the payment methodology required by [the statute] sets future payments using the Federal FY 1984 base-period amounts as the initial starting point, we believe that it is very important that inappropriate costs not be included in the base-period amount." 53 Fed. Reg. 36,591 (1988). The agency believed that it had erroneously reimbursed hospitals for various "misclassified" and "nonallowable" costs from fiscal year 1984, *id.* at 36,591-92, and that these errors explained in part why "the range of per resident amounts for the GME base year varies from below $10,000 to over $100,000 per resident," *id.* at 36,593. As an example of a misclassified cost, the Secretary cited "physicans' compensation costs for services to the hospital that are not specifically and directly related to approved educational activities," and as an illustration of a nonallowable cost, the agency referred to "the costs of a medical school related to a hospital by common ownership or control . . . that are not directly and specifically related to patient care furnished in the hospital." *Id.* at 36,591-92. The Secretary concluded that the GME Amendments "would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later." *Id.* at 36,593.

In the preamble to the regulations, the Secretary responded to a comment that concerns about past erroneous reimbursements were "unfounded," by citing "several sit-

uations . . . brought to our attention in which physicians' costs incurred for activities unrelated to GME . . . costs [were] misclassified as GME costs or excessive administrative and general service costs were allocated to the GME cost center." 54 Fed. Reg. 40,300 (1989). The Secretary based the need for reauditing on the fact that "GME costs were not given sufficient scrutiny at the time because of the many changes taking place in Medicare generally." *Id.* at 40,301. Finally, the Secretary reiterated that the 1984 GME costs should be revisited because it was "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." *Id.*

The agency's belief that Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursements to health care providers can hardly be deemed unreasonable or inconsistent with the congressional purpose of erecting a new and more accurate reimbursement methodology. *See generally Shell Oil Co. v. EPA*, 950 F.2d 741, 755 (D.C. Cir. 1991); *Ohio v. Dep't of the Interior*, 880 F.2d 432, 441 (D.C. Cir. 1989). The agency described its concerns on the rulemaking record and reasonably interpreted a statutory ambiguity to permit reauditing of 1984 GME costs in determining the "average amount recognized as reasonable" for the GME costs of each FTE resident. Moreover, recognizing that its own three year window for reassessing NPRs for 1984 had closed, the agency reasonably determined that its reauditing should only impact the base period per resident amount calculation that, by statute, would be used to compute reimbursements from 1985 onward. We do not accept, therefore, the Hospitals' argument that the agency acted unreasonably in failing to reaudit their 1984 GME costs within the three year regulatory reopening period. The three year gap between the 1986 enactment of the GME Amendments and promulgation of the agency's regulations in 1989, while unfortunate, was not an unreasonable period for developing, proposing, permitting

comment, and finalizing a regulatory framework for a complex statutory scheme.[7]

C. *Retroactivity*

As an alternative ground for its decision invalidating the agency's reauditing regulations, the district court found the regulations to be impermissibly retroactive because they allegedly lacked specific authorization in the statute. Mem. op. at 20-22. Because the 1986 GME Amendments require HHS to determine "an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985," 42 U.S.C. § 1395ww (h)(2), the statute, by its very terms, is intended to have some retroactive effect. *See Kaiser Aluminum & Chem. Corp. v. Bonjorno*, 494 U.S. 827, 837 (1990) (regarding retroactivity, "where the congressional intent is clear, it governs"). Accordingly, any regulations implementing the statute will necessarily be retroactive *insofar* as they will alter the methodology for reimbursements beginning in 1985. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("*Georgetown I*") ("[C]ongressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this result."). However, that does not answer the separate question of whether reauditing the 1984 GME cost figures to determine a base period amount for computing payments from 1985 forward is improperly retroactive. We conclude that the reauditing is not an exercise in retroactive rulemaking at all, let alone an impermissible one. The reaudit carries no impact for actual 1984 reimbursements and will be used only to calculate future reimbursements. A law is retroactive if it " 'takes away or impairs vested rights acquired under existing law,

[7] We address here only the *facial* validity of HHS's reauditing regulations. Each hospital has 180 days after the calculation of its base period per resident amount to challenge the accuracy of any determination before the Board. 42 C.F.R. § 413.86(e)(1)(v).

or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past.' " *Ass'n of Accredited Cosmetology Sch. v. Alexander*, 979 F.2d 859, 864 (D.C. Cir. 1992) (quoting *Neild v. Dist. of Columbia*, 110 F.2d 246, 254 (D.C. Cir. 1940) (internal quotations omitted)). The Secretary's reauditing regulations do none of these things.

In *Association of Accredited Cosmetology Schools*, a new statute and its implementing regulations made past loan default rates an acceptable basis for terminating schools from a federally guaranteed student loan ("GSL") program, even though those rates were permissible under prior law. 979 F.2d at 859. We explained:

> Instead of undoing past eligibility, . . . the Act and the regulations merely require the Department [of Education] to look at schools' past default rates in determining future eligibility for GSL program participation. We regard this requirement as no different in substance than a lender's rule against extending credit to applicants with negative credit histories. Several cases have established that such a requirement does not operate retroactively. *See Reynolds v. United States*, 292 U.S. 443, 449 (1934)) (holding that "[a] statute is not rendered retroactive merely because the facts or requisites upon which its subsequent action depends, or some of them, are drawn from a time antecedent to the enactment"); *Neild v. District of Columbia*, 110 F.2d 246, 255 (D.C. Cir. 1940) (holding that a law is not retroactive simply because it depends on " 'antecedent facts for its operation' ") (quoting *Lewis v. Fidelity & Deposit Co.*, 292 U.S. 559, 571 (1934)). . . . We accordingly hold . . . that the Act and the regulations are not retroactive.

Id. at 865-66; *see also Campbell v. United States*, 809 F.2d 563, 571 (9th Cir. 1987).

The situation is similar here. Rather than altering 1984 reimbursements, HHS's regulations simply permit the Secretary to use reaudited versions of those past figures for the purpose of determining reimbursements in succeeding years. *Cf. Georgetown I*, 488 U.S. at 204 (regulation which changed reimbursement methodology and allowed HHS to recoup past payments under new methodology deemed impermissibly retroactive). Although in this case the GME Amendments themselves operate retroactively to alter the reimbursement methodology from July 1, 1985 onward, that contextual difference does not make the use of the reaudited 1984 figures in the new methodology retroactive in its own right. To put it another way, within the limited statutory retroactivity, the Secretary's reauditing regulations add nothing further that is retroactive: the regulations contemplate only the use of past information for subsequent decisionmaking. "In view of that conclusion, we need not consider [the Hospitals'] argument that . . . the [statute] does not speak with the requisite clarity to justify retroactive rulemaking." *Ass'n of Accredited Cosmetology Sch.*, 979 F.2d at 866.

III. CONCLUSION

For the foregoing reasons, we reverse the district court and uphold the facial validity of HHS's reauditing regulations.

So ordered.

Supreme Court, U.S.
FILED
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OFFICE OF THE CLERK

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No. 96-1375

In the Supreme Court of the United States

OCTOBER TERM, 1996

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
PETITIONER

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Under a 1986 amendment to the Medicare Act, 42 U.S.C. 1395ww(h), Congress enacted a new methodology for reimbursing graduate medical education (GME) costs incurred by hospitals that participate in the Medicare program. The amendment directed the Secretary of Health and Human Services to "determine," for each hospital's cost reporting year that began during fiscal year 1984 (the base year), the "average amount recognized as reasonable" under the Medicare Act for direct GME costs for each full-time-equivalent resident. 42 U.S.C. 1395ww(h)(2)(A). The amendment further directed the Secretary to use that base-period per-resident amount, adjusted for inflation, to calculate the hospital's GME cost reimbursement for reporting periods beginning on or after July 1, 1985. 42 U.S.C. 1395ww(h)(2); see 42 C.F.R. 413.86. The question presented is:

Whether the Secretary reasonably construed 42 U.S.C. 1395ww(h) to authorize the reaudit of a hospital's previously approved, but possibly unreasonable or nonallowable, GME costs incurred in the base year, for the purpose of determining the reimbursement due in subsequent years.

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BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-3a) is reported at 91 F.3d 57. The opinion of the district court (Pet. App. 4a-8a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on July 26, 1996. The petition for rehearing was denied on September 30, 1996. Pet. App. 9a. Justice Thomas extended the time within which to file a petition for a writ of certiorari to and including February 27, 1997, and the petition was filed on that date. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services.[1] When eligible patients receive those services, the Secretary reimburses the providers of the services under the Medicare Act and the Secretary's implementing regulations. Under the regulations, the costs of certain educational programs for health professional trainees, including programs for interns and residents known as graduate medical education (GME) programs, are "allowable cost[s]" for which a hospital may receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a).

A provider's total allowable Medicare payment is based on a "cost report" that it must prepare after the close of its fiscal year. 42 C.F.R. 405.1801. The cost report is filed with a "fiscal intermediary" (usually an insurance company) designated by the Secretary. It shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. 413.20(b), 413.24(f). The intermediary analyzes the cost report, audits it if necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount to be paid for Medicare services during the reporting period. 42 C.F.R. 405.1803.

[1] Part B is a voluntary supplementary insurance program covering physicians' charges and other medical services. 42 U.S.C. 1395k, 1395*l*, and 1395x(s).

A provider dissatisfied with the NPR may timely request a hearing before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. 1395*oo*(a) and (b); 42 C.F.R. 405.1835, 405.1837. The PRRB's decision is "final" unless, within 60 days, the Secretary reverses, affirms, or modifies it. 42 U.S.C. 1395*oo*(f)(1). By regulation, a determination by the intermediary, the PRRB, or the Secretary may be "reopened" within three years (or at any time if there has been fraud) with respect to findings at issue in the determination. 42 C.F.R. 405.1885, 405.1807.[2]

2. From 1966 through 1982, providers of services under Part A ordinarily were reimbursed for Medicare-covered patient care to the extent the costs were reasonable. 42 U.S.C. 1395f(b)(1). The reasonable cost calculation generally was based on the "cost[s] actually incurred," as long as the services were necessary. 42 U.S.C. 1395x(v). The Act authorized the Secretary to issue regulations defining the payment due under that statutory standard. 42 U.S.C. 1395hh, 1395x(v)(1)(A). In 1983, Congress introduced a prospective payment system (PPS) that establishes fixed payment rates for the operating costs of

[2] Providers may obtain judicial review of any "final decision" of the PRRB or of the Secretary, if the Secretary excercises the right of review. 42 U.S.C. 1395*oo*(f)(1). They may also obtain expedited judicial review of any action taken by a fiscal intermediary "which involves a question of law or regulations relevant to the matters in controversy," if the PRRB determines that "it is without authority to decide the question" or fails to make a timely determination of its authority to decide the question. 42 U.S.C. 1395*oo*(f)(1). The Board is authorized by regulation, 42 C.F.R. 405.1842(g)(2), to deny expedited judicial review if it finds that the issue on which review is sought is intertwined with disputed factual or legal issues that it is authorized to decide.

providing inpatient care to program beneficiaries. See 42 U.S.C. 1395ww(d) (1988 & 1991 Supp. III). Costs incurred in connection with GME programs were excluded from the PPS scheme. Until July 1985, hospital GME costs continued to be reimbursed on a "reasonable cost" basis. 42 U.S.C. 1395ww(a)(4) and (d)(1)(A) (1988 & 1991 Supp. III).

In the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, however, Congress changed the method for calculating GME costs by providing that, subject to updating for inflation, the calculation of GME costs to be reimbursed in all subsequent years would be based on the amount of allowable GME costs incurred by the provider for a fiscal year that began between October 1, 1983, and September 30, 1984 (the base year). See Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, Tit. IX, § 9101, 100 Stat. 153-155, 42 U.S.C. 1395ww(h) (the GME Amendment); see also 42 C.F.R. 413.86(e)(1)(i)(A). Specifically, the GME Amendment provides, as the initial step in the reimbursement process, that "[t]he Secretary shall determine [for the base year] the average amount recognized as reasonable" under the Act for direct GME costs for each full-time equivalent (FTE) resident. 42 U.S.C. 1395ww(h)(2)(A). Thus, the Secretary was directed to calculate a per-resident amount for each hospital by dividing the amount of GME costs "recognized as reasonable" for the base period of 1984 (numerator) by the number of FTE interns and residents working at the hospital in 1984 (denominator). To determine a hospital's GME reimbursement for any given year, the allowable GME per resident amount, adjusted for inflation, is multiplied by the number of FTE residents working in the hospital during the year in question and the hospital's Medicare patient load that year. 42 U.S.C. 1395ww(h)(3). Congress instructed the Secretary to apply the new method retroactively to "hospital cost reporting periods beginning on or after July 1, 1985." GME Amendment, § 9202(b), 100 Stat. 175.

On September 21, 1988, the Secretary published and invited comment on proposed regulations implementing the GME Amendment. 53 Fed. Reg. 36,589 (1988). Although the Secretary already had reimbursed most hospitals for 1984 GME costs, and in some cases the three-year period for administratively reopening the determinations relevant to those payments had expired, the proposed regulations authorized fiscal intermediaries to reexamine providers' costs from the base year and to conduct a reaudit if the claimed base year costs appeared to include "misclassified or non-allowable costs," or were "unreasonably high." *Id.* at 36,592. The Secretary explained that the agency had reason to believe some "questionable" GME costs had been "erroneously reimbursed" to providers for the base year. *Id.* at 36,591. Because the Secretary concluded that those past mistakes should not be "perpetuated" under the new GME cost reimbursement methodology, the reauditing authority was needed to ensure an "accurate" determination of providers' base-year GME costs. *Id.* at 39,591-39,592. The Secretary believed that "the provisions of section 1886(h) of the Act would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later." *Id.* at 36,593.

In the preamble to the final regulations, issued on September 29, 1989 (see 54 Fed. Reg. 40,286-40,301 (1989)), the Secretary reiterated that it was "hard to

believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301 (1989). The Secretary assured providers that, in reauditing 1984 GME costs, "no new reimbursement principles will be applied * * * ; [r]ather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied." *Ibid.* In response to comments that the proposed reexamination and reaudits conflicted with the three-year reopening limitation in 42 C.F.R. 405.1885, the Secretary stressed that the reaudits would not be used to recoup erroneous reimbursement for cost reports that had been settled for more than three years under the reopening regulation. 54 Fed. Reg. 40,302 (1989). Rather, they would be used to recalculate base year costs "solely for purposes of computing the per resident amount" under the new method for reimbursing GME costs for 1985 and "subsequent years still subject to reopening." *Id.* at 40,301, 40,302.[3]

In late 1990, fiscal intermediaries began to conduct redeterminations of GME base-year amounts for teaching hospitals that provide Medicare services, including petitioner St. Paul-Ramsey Medical Center. The reaudit of petitioner resulted in a determin-

[3] The Secretary also modified 42 C.F.R. 405.1885 to permit hospitals to request a reopening of a cost report settled more than three years before if the reaudit resulted in a disallowance based on "misclassified" base period GME costs. 54 Fed. Reg. at 40,301. The purpose of that modification was to allow the hospitals to demonstrate that, if the reaudit showed the disallowed cost should have been classified as an operating rather than a GME cost, their reimbursement rate for operating costs should be increased. *Ibid.*

ation that petitioner's allowable GME costs for its base year were $5,494,955, which was $4,397,689 less than the $9,892,644 in GME costs the intermediary approved on February 28, 1986. See Pet. App. 2a.[4] On August 13, 1991, petitioner appealed the intermediary's determination to the PRRB. Pet. 8; Admin. Rec. 119. Petitioner challenged the validity of the GME regulation authorizing the reaudit, arguing that the GME Amendment required the Secretary to determine petitioner's average amount of reasonable GME costs for the base period by using the amount reflected in petitioner's NPR for the base period and reimbursed by the Secretary, and not the amount resulting from the reaudit. On September 28, 1994, the PRRB concluded that it lacked authority to invalidate the GME regulation, thereby allowing petitioner to seek expedited judicial review under 42 U.S.C. 1395*oo*(f)(1). Admin. Rec. 1-4; see note 2, *supra*.

5. Petitioner filed suit in the United States District Court for the District of Minnesota challenging the validity of the GME reaudit regulation. On the parties' cross-motions for summary judgment, the district court upheld the GME reaudit regulation.

[4] Although it was evident that petitioner had received excessive reimbursement for 1984 GME costs, no recoupment action was taken against it by the intermediary or the Secretary because petitioner's 1984 cost report had been settled for more than three years and could not be reopened under 42 C.F.R. 405.1885. Instead, the intermediary notified petitioner that it would use the reaudited GME cost amount solely to determine petitioner's reimbursable GME amount for all cost reporting years beginning on or after July 1, 1985, for which the three-year reopening period had not already elapsed. Pet. 7-8; see 42 C.F.R. 413.86(e)(1)(iii).

Pet. App. 4a-8a. The court observed (*id.* at 7a) that petitioner's arguments supporting its challenge to the reaudit regulation had been considered and rejected by the District of Columbia Circuit in *Administrators of the Tulane Educational Fund* v. *Shalala*, 987 F.2d 790 (1993), cert. denied, 510 U.S. 1064 (1994) (see Pet. App. 38a-54a), and by the District Court for the Northern District of Ohio in *The Toledo Hospital* v. *Shalala*, No. 3:94cv7080 (June 23, 1995), rev'd, 104 F.3d 791 (6th Cir. 1997). The court found those decisions "persuasive, thorough, well-reasoned and indistinguishable from the present case." Pet. App. 8a. Accordingly, the court "adopt[ed]" the analyses of those decisions and granted summary judgment in favor of the Secretary. *Ibid.*

6. The court of appeals affirmed. Pet. App. 1a-3a. The court explained that "the Secretary's reaudit regulations must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*." *Id.* at 3a. Thus, the court concluded that "[t]he statute is ambiguous, and the reaudit regulations are not an exercise in retroactive rulemaking." *Ibid.* The court observed that "[w]hile it would have been far preferable had the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements, the substance of the regulations is clearly reasonable." *Ibid.*

ARGUMENT

The court of appeals correctly sustained the Secretary's construction of the GME Amendment and the regulation allowing reaudits of base period GME costs in determining the average of amount of costs "recognized as reasonable" under the Medicare Act. We nevertheless agree with petitioner that the Court

should grant certiorari in this case. A recent decision of the Sixth Circuit, *The Toledo Hospital* v. *Shalala*, 104 F.3d 791 (1997) (see Pet. App. 20a-37a), is in conflict with the decision below and the decision of the D.C. Circuit in *Tulane*, and the question presented is of sufficient importance to warrant this Court's review.

1. a. The court of appeals properly applied the two-step analysis of this Court's decision in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842, 843 (1984). In the GME Amendment, Congress directed the Secretary to "determine" for each teaching hospital the "average amount recognized as reasonable under this subchapter" for GME costs in fiscal year 1984, and to "determine" from that a per "resident amount." 42 U.S.C. 1395ww(h)(2). The court below correctly concluded that "[t]he statute is ambiguous." Pet. App. 3a. As the D.C. Circuit in *Tulane* pointed out, the phrase "recognized as reasonable" could be construed either as commanding the use of the reimbursement amount that had originally been calculated by the fiscal intermediary and had become final by operation of the three-year regulatory limitation on reopening, see 42 C.F.R. 405.1885 and 405.1807, or, alternatively, as permitting the use of an amount more recently determined to be "reasonable" through a reauditing process.

In petitioner's view (Pet. 12-16), the GME Amendment's direction to the Secretary to "determine, [for the base year], the average amount recognized as reasonable under this subchapter" required the Secretary to derive an "average" by dividing the amount already established in a hospital's audited NPR for cost reporting year 1984 (numerator) by the number

of full-time residents for that year (denominator). As the District of Columbia Circuit observed in *Tulane*, however, "[t]he statutory text certainly does not address this administrative dilemma directly," and there is "no convincing evidence, direct or indirect, that Congress meant to prohibit corrective reauditing of the 1984 GME cost figures." Pet. App. 46a; see also *id.* at 49a n.6 ("because the statute directs the HHS to '*determine*' the '*average*' amount of GME costs per FTE resident 'recognized as reasonable,' it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula").

In the face of the Act's ambiguity, the Secretary reasonably construed Congress's mandate to authorize a new determination of GME costs for the base year under the standard of reasonableness established by the Medicare Act. Further, because the Secretary could reasonably assume that "Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursement to health care providers," Pet. App. 51a, it was reasonable for the Secretary to adopt an interpretation that would minimize the chance of carrying forward past errors. Indeed, Congress has, by statute, specifically recognized the Secretary's implementation of the GME Amendment and, far from disapproving that implementation, has instead chosen only to mitigate its financial impact. See Section 4004(a) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388-39 (42 U.S.C. 1395ww note) (prohibiting, until October 1, 1991, the Secretary's recovery of GME overpayments accrued during cost reporting years 1985 through 1991 resulting from the new payment methodology of 42 U.S.C. 1395ww(h),

and limiting thereafter the recovery of those accrued overpayments to 25 percent of the amount of the overpayments in each of the succeeding four fiscal years).[5]

b. Contrary to petitioner's contention (Pet. 19-22), the court of appeals also correctly held that the reaudit regulation is "not an exercise in retroactive rulemaking." Pet. App. 3a. Congress expressly provided the Secretary some authority to issue rules retroactively, because it made the GME Amendment (which was enacted on April 7, 1986) applicable to cost reporting periods beginning on or after July 1, 1985. By necessary implication, the procedures for calculating GME costs in the GME regulations that the Secretary subsequently issued in 1989 may be used to calculate reimbursement for cost reporting periods beginning July 1, 1985.

The intermediary's reaudit of the base year does not introduce any additional element of retroactivity beyond the authority conferred by the GME Amendment itself. The reaudit figures are not used to recoup reimbursement for any cost-reporting year for which the three-year reopening period has elapsed. 54 Fed. Reg. 40,302 (1989); 42 C.F.R. 413.86(e)(i)(iii). Accordingly, the reaudit regulation neither takes

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[5] The Conference Report also makes clear that Congress was fully aware of the Secretary's implementation of the GME Amendment through recoupment of past payments determined to exceed the amount allowable under 42 U.S.C. 1395ww(h), "expect[ed] the Secretary to recoup overpayments identified as a result of implementing this policy over a four year period," and contemplated that the Secretary would not make continued overpayments following a determination that past payments exceeded the amount permitted by 42 U.S.C. 1395ww(h). H. R. Conf. Rep. No. 964, 101st Cong., 2d Sess. 719 (1990).

away nor impairs any rights petitioner acquired under previously existing law. See *Landgraf* v. *USI Film Products*, 511 U.S. 244, 269, 280 (1994). Similarly, because the reaudit regulation requires only a determination of past facts for purposes that have only prospective effect, the regulation does not make a retroactive change. 511 U.S. at 269-270 n.24 ("a statute 'is not made retroactive merely because it draws upon antecedent facts for its operation'" (quoting *Cox* v. *Hart*, 260 U.S. 427, 435 (1922)); *Reynolds* v. *United States*, 292 U.S. 443, 449 (1934) ("[a] statute is not rendered retroactive merely because the facts * * * upon which its subsequent action depends * * * are drawn from a time antecedent to the enactment"). For those reasons, the D.C. Circuit in *Tulane* correctly concluded that "within the limited statutory retroactivity, the Secretary's reauditing regulations add nothing further that is retroactive," because "the regulations contemplate only the use of past information for subsequent decisionmaking." Pet. App. 54a.

2. Although the decision of the court of appeals is correct, we agree with petitioner that the Court should grant certiorari in this case. The Sixth Circuit's recent decision in *Toledo*, *supra* (see Pet. App. 20a-37a), directly conflicts with the decisions of the court below and the D.C. Circuit in *Tulane*. In *Toledo*, the Sixth Circuit held that the GME Amendment required the Secretary to use the initial 1984 GME cost figures in calculating the reimbursement formula for future reimbursements and prohibited the use of reaudited figures. *Id.* at 30a-34a. The Sixth Circuit faulted the conclusion by the court below and the decision in *Tulane* that the language of 42 U.S.C. 1395ww(h)(2) is ambiguous. Pet. App. 28-29a.

It reasoned that because Congress "knew that there was an administrative scheme in place that would determine the reasonable GME costs for providers for fiscal [year] 1984," "Congress must have contemplated that the Secretary would use those administratively determined reasonable costs as the basis for calculating the average GME cost per full-time-equivalent resident." *Id.* at 30a-31a. The court also found that, even if the GME Amendment is ambiguous, the Secretary's construction was unreasonable. *Id.* at 34a-37a. Because the Sixth Circuit concluded that the reaudit regulation failed *Chevron*'s two-step analysis, the decision in *Toledo* directly conflicts with the instant decision of the Eighth Circuit and the decision of the D.C. Circuit in *Tulane*.

Furthermore, the proper interpretation of the GME Amendment presents an important and recurring issue that has a major fiscal impact on the administration of the Medicare program. More than 1,300 hospitals nationwide received notices of average per-resident amounts, reflecting the hospital's base year GME costs. The PRRB's records reflect that 624 hospitals sought administrative review of those notices. As of mid-April 1997, 84 administrative appeals were still pending. Moreover, the Secretary believes that the hospitals affected by the GME Amendment will continue to seek judicial review of the validity of the reaudit regulation.[6] Even if the reaudit regulation remains invalid only in the Sixth Circuit, the *Toledo* decision nonetheless will have significant

[6] Another challenge to the GME reaudit regulation is pending in the United States District Court for the District of Arizona. *Samaritan Health Systems* v. *Shalala*, No. CIV 95-1032 PHX-RCB (filed May 24, 1995).

financial impact on the Medicare program. There are 17 pending administrative appeals that could be affected by the Sixth Circuit's decision. We have been informed that for those hospitals alone, the amount at stake for past fiscal years could exceed $100 million. Thus, the Court's resolution of the Secretary's authority under the GME Amendment is warranted.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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APRIL 1997

Supreme Court, U.S.
FILED
JUL 25 1997
CLERK

(3)

No. 96-1375

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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JOINT APPENDIX

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PETITION FOR CERTIORARI FILED FEBRUARY 27, 1997
CERTIORARI GRANTED JUNE 2, 1997

40 P

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NOTICE

The following documents have been omitted in the printing of this Appendix. They may be found in the Appendix to the Petition for Writ of Certiorari at the following pages:

Opinion of the United States Court of Appeals for the Eighth Circuit	1a
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DOCKET ENTRIES

United States District Court
for the District of Minnesota

DATE	NO.	PROCEEDINGS
12/1/94	1	COMPLAINT—Summons issued. Assigned to Judge Richard H. Kyle per master list and referred to Magistrate Judge Ann D. Montgomery. (18 pages) (ps) [Entry date 12/02/94]
12/2/94	2	RETURN OF SERVICE executed upon U. S. Atty on 12/2/94. (3 pages) Summons not returned. (ps) [Entry date 12/21/94]
1/17/95	3	SUMMONES filed. (affidavits previously filed) 6 pages (ps)
1/25/95	5	MOTION by defendant to extend time to answer complaint. (to Magistrate Judge Ann D. Montgomery) 4 pages (ps) [Entry date 01/27/95]
1/26/95	4	ANSWER. (6 pages) (ps) [Entry date 01/27/95]
1/27/95	—	Referred Neil H. Koslowe to clerk to send government admission papers. (ps)
1/27/95	—	Referred Glenn W. Kendall to clerk to send government admission papers. (ps)
2/7/95	6	PETITION AND ORDER for admission pro hac vice (Clerk Francis E. Dosal) on behalf of defendant by Neil H. Koslowe. (1 page) (ps)
3/9/95	7	ORDER REGARDING FILING REPORT OF RULE 26(f) MEETING (Magistrate Judge Ann D. Montgomery 3/8/95) due no later than April 21, 1995. (4 pages) (ps)

DATE	NO.	PROCEEDINGS
3/17/95	8	MOTION by plaintiff to admit Ronald Sutter pro hac vice. (3 pages) (ps) [Entry date 03/20/95]
3/31/95	9	TRANSCRIPT. —separate— (ps) [Entry date 04/04/95]
4/3/95	10	PETITION AND ORDER for admission pro hac vice (Clerk Francis E. Dosal) on behalf of plaintiff by Ronald N Sutter (2 pages) (ps) [Entry date 04/05/95]
4/13/95	11	JOINT REPORT OF RULE 26(f) MEETING. (5 pages) (ps)
5/17/95	12	MOTION by plaintiff for summary judgment. (to Judge Richard H. Kyle) ret. 7/31/95 at 8:00 a.m. (3 pages) (ps) [Entry date 05/18/95]
5/17/95	13	MEMORANDUM and EXHIBITS by plaintiff in support of motion for summary judgment. [12-1] 44 pages (ps) [Entry date 05/18/95]
5/17/95	14	AFFIDAVIT and EXHIBITS of Kent G. Harbison regarding motion for summary judgment. [12-1] 50 pages (ps) [Entry date 05/18/95]
6/8/95	15	MOTION by defendant for summary judgment. (to Magistrate Judge Ann D. Montgomery) 1 page (ps) [Entry date 06/09/95]
6/8/95	16	MEMORANDUM by defendant in support of motion for summary judgment and MEMORANDUM in opposition to plft's motion for summary judgment. [15-1] 34+ pages (ps) [Entry date 06/09/95]
6/28/95	17	MEMORANDUM by pltf in opposition to dft's motion for summary judgment [12-1] 35pgs (pk) [Entry date 06/30/95]

DATE	NO.	PROCEEDINGS
6/28/95	18	EXHIBITS ACCOMPANYING PLTF'S MEMORANDUM 19pgs (pk) [Entry date 06/30/95]
7/11/95	19	MOTION by defendant for summary judgment. (to Judge Richard H. Kyle) ret. 7/31/95 at 8:00 a.m. [2 pages] (ps)
7/17/95	20	CONSENT MOTION by defendant to extend time file reply. (to Magistrate Judge Ann D. Montgomery) 3 pages (ps) [Entry date 07/19/95]
7/17/95	21	ORDER (Judge Richard H. Kyle 7/17/95) granting deft's motion to extend time to file reply to 7/26/95. [20-1] (cc: all counsel) 1 page (ps) [Entry date 07/19/95]
7/26/95	22	REPLY MEMORANDUM by defendant to plaintiff's memorandum [17-1] in opposition to defendant's motion for summary judgment (33 pgs) (dl) [Entry date 07/27/95]
7/31/95	23	MINUTES: (Judge Richard H. Kyle / Angie Threlkeld) taking under advisement deft's motion for summary judgment. [19-1] 1 page (ps)
8/8/95	24	MEMORANDUM OPINION AND ORDER (Judge Richard H. Kyle 8/8/95) granting deft's motion for summary judgment [19-1] [15-1]; denying pltf's motion for summary judgment [12-1]; and pltf's complaint is dismissed with prejudice. (cc: all counsel) 6 pages (ps) [Entry date 08/09/95]
8/8/95	25	JUDGMENT entered. (1 page) (ps) [Entry date 08/09/95]
10/2/95	26	NOTICE OF APPEAL by plaintiff St. Paul-Ramsey Med from Judge Richard H. Kyle decision dated 8/8/95 [24-2], receipt number 122373 (2pgs.). (lg)

DATE	NO.	PROCEEDINGS
10/2/95	—	DELIVERED TWO CERTIFIED and one uncertified copy of each of the following to the Court of Appeals, St. Paul Office: Notice of Appeal, Order, Judgment and District Court Clerk's Docket Entries. Copy of Notice of Appeal mailed to counsel (lg)
10/6/95	—	NOTIFICATION BY CIRCUIT COURT of Appellate Docket Number 95-3477MNST Filed 10/2/95 Doc. #26. (pk) [Entry date 10/10/95]

DOCKET ENTRIES

United States Court of Appeals
for the Eighth Circuit

DATE	PROCEEDINGS
10/5/95	Civil Case Docketed. (jmb)
10/5/95	CERTIFIED copies notice of appeal, docket entries, order and judgment of 8/08/95. [95-3477] [625503] (jmb)
10/5/95	BRIEFING SCHEDULE: DR aplnt due on 10/16/95 Method of Apndx due on 10/16/95 DR aplee due on 10/25/95 Administrative Record or Transcript due 11/14/95 ; Appendix due on 11/14/95 ; Brief of aplee due on 12/14/95 ; Reply brief due on 12/28/95 (jmb)
10/16/95	APPEARANCE for appellant, attorney Ronald N. Sutter [95-3477] [629056] (sek)
10/16/95	DESIGNATION of record received from Appellant St. Paul Ramsey. Type of appendix: JOINT APPENDIX [95-3477] (sjo)
11/2/95	APPEARANCE for appellee, attorney Neil H. Koslowe [95-3477] [635606] (jmb)
11/20/95	BRIEF FILED—Brief of Appellant- St. Paul Ramsey 44 pgs w/addendum—11 copies—w/service 11/14/95 . Defects: Standard of Review [95-3477] [642396] (sjo)
11/20/95	RECORDS received: Joint Appendix, consisting of 1 Volume(s) 3 copies. [95-3477] (sjo)
11/20/95	RECORDS received: Administrative Record consisting of 1 Volumes 3 copies [95-3477] (sjo)
12/13/95	Brief Correction(s) received from Appellant St. Paul Ramsey. Correction(s): Standard of Review. [95-3477] (sjo)

DATE	PROCEEDINGS
12/15/95	BRIEF FILED—Brief of Appellee—Donna E. Shalala. 37 pgs—w/addendum—10 copies—w/ service 12/14/95, Type Size & Addendum okay per MEG. [95-3477] [652165] (yml)
12/15/95	MOTION of aplnt, St. Paul Ramsey, for extension of time to file reply brief until 1/8/96 . [95-3477] [652730] w/service 12/14/95 (skh)
12/19/95	ORDER filed: granting appellant motion extension of time to file reply brief. [652730-1] [652731] Reply brief now due on 1/8/96 . (skh)
12/29/95	TO SCREENING—to St. Paul [95-3477] (smg)
1/12/96	MOTION of aplnt, St. Paul Ramsey, to file brief out of time [95-3477] [661309],—NO ACTION TAKEN. (brief timely filed) w/service 1/10/96 (sjo)
1/12/96	BRIEF FILED—Reply brief—St. Paul Ramsey . 25 pgs—11 copies—w/service 1/10/96 . [95-3477] [661312] (sjo)
1/12/96	RETURNED from Screening (15) [95-3477] (smg)
5/6/96	*SET FOR ARGUMENT*—June in St. Paul. [95-3477] (mel)
6/14/96	ARGUED AND SUBMITTED IN ST. PAUL TO JUDGES James B. Loken, Circuit Judge, Donald R. Ross, Circuit Judge, David R. Hansen, Circuit Judge . Ronald N. Sutter for Appellant St. Paul Ramsey . Neil H. Koslowe for Appellee Donna E. Shalala . Rebuttal by: Ronald N. Sutter . RECORDED. [95-3477] (lcd)
7/26/96	THE COURT: James B. Loken, Donald R. Ross, David R. Hansen . PER CURIAM OPINION FILED: PUBLISHED [95-3477] [737613] (paw)

DATE	PROCEEDINGS
7/26/96	JUDGMENT: James B. Loken, Donald R. Ross, David R. Hansen : The judgment of the lower court is AFFIRMED in accordance with the opinion. [95-3477] [737618] (paw)
9/9/96	PETITION for rehearing by the panel, filed by Appellant St. Paul Ramsey w/service 9/6/96, TO COURT. [96-3477] (lcd)
9/10/96	ERRATA sheet received for rehearing petition filed by Appellant St. Paul Ramsey . [95-3477] (lcd)
9/30/96	JUDGE ORDER: denying petition for panel rehearing [754556-1] filed by St. Paul Ramsey [95-3477] [762552] (lcd)
10/9/96	MANDATE ISSUED [95-3477] (lcd)
10/15/96	RECEIPT for Mandate. [95-3477] [768222] (lcd)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

No. 3-94-1522

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
640 Jackson Street, St. Paul, Minnesota 55101,
Plaintiff,

v.

DONNA E. SHALALA, Ph.D.,
Secretary, Department of Health and Human Services,
200 Independence Avenue, S.W., Room 614-G,
Washington, D.C. 20201,
Defendant.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND FOR SUMS DUE UNDER THE MEDICARE STATUTE

Plaintiff states:

I. INTRODUCTION

1. This suit challenges the validity of a Medicare regulation of extraordinary retroactive effect issued by the Secretary of the Department of Health and Human Services ("the Secretary"). Application of this regulation has caused plaintiff and many other teaching hospitals across the country great financial harm and prejudice.

2. In April 1986, Congress enacted a new Medicare payment methodology for graduate medical education ("GME") costs, effective for hospital cost reporting years beginning on or after July 1, 1985. Payment under this methodology (common known as the "GME per resident

amount" methodology) is based on "the average amount [per resident] recognized as reasonable under [the Medicare statute] for direct graduate medical education costs of the hospital" for a base year, updated for inflation and multiplied by the hospital's number of full-time equivalent residents in each subject year. The base year is each hospital's Medicare cost reporting year beginning in federal fiscal year 1984, during which year Medicare reimbursed teaching hospitals the "reasonable cost" of GME.

3. Plaintiff's base year was its 1984 fiscal year (*i.e.*, its cost reporting year beginning January 1, 1984, and ending December 31, 1984). Utilizing the "reasonable cost" standards then in effect, the hospital's Medicare intermediary (the Secretary's agent) completed the *final* audit for that year on February 28, 1986. As of March 1, 1989, the Secretary was legally precluded from reopening the hospital's 1984 fiscal year.

4. The Secretary did not promulgate regulations to implement the GME statute until September 1989, three and a half years after the statute's enactment. Contrary to the statute, these regulations do not require that payment under the GME per resident amount methodology be based on the amount of GME costs "recognized as reasonable" for the base year. Instead, even though hospital base years were closed and no longer subject to reopening under long-established Medicare principles and even though hospitals were no longer required even to retain the supporting documentation for their base year, the regulations authorized the Medicare intermediaries to reaudit a hospital's base year for purposes of the GME per resident amount methodology and use the results of the reaudit, rather than the results of the *final* audit applicable to the GME base year itself, to compute payment under the GME per resident amount methodology. The Secretary thereafter issued lengthy instructions to be used for the reaudits that significantly altered the "reasonable

cost" reimbursement standards in effect during the base year.

5. In late 1990, pursuant to the Secretary's GME "reaudit" regulations, plaintiff's Medicare intermediary began reauditing plaintiff's 1984 cost reporting year for purposes of the GME per resident amount methodology. In doing so, the intermediary retroactively applied the rigorous new standards in the Secretary's 1990 instructions. Not surprisingly under all these circumstances, the determination of plaintiff's allowable GME base year costs that the intermediary eventually issued in 1991 as a result of the reaudit was significantly lower than the determination it issued in 1986 in the final audit for the base year itself. The Secretary has used, and continues to use, the 1991 reaudit determination (rather than the 1986 determination applicable to the base year itself) to compute plaintiff's payment entitlement under the GME per resident amount methodology for the hospital's 1986 and subsequent cost reporting years.

6. Plaintiff contends that the Secretary's "reaudit" regulations are contrary to the Medicare statute, violative of well-established proscriptions against retroactive rulemaking, arbitrary and capricious, and otherwise contrary to law. Plaintiff seeks, among other things, an order invalidating the Secretary's "reaudit" regulations and requiring the Secretary to use the GME costs "recognized as reasonable" in the *final* audit applicable to the GME base year itself to compute payment under the GME per resident amount methodology.

II. JURISDICTION AND VENUE

7. This action arises under title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (the "Medicare statute"), and the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*

8. This Court has jurisdiction under 42 U.S.C. § 1395oo(f)(1) and 28 US.C. §§ 1331 and 1361.

9. Venue lies in this judicial district pursuant to 42 U.S.C. § 1395oo(f)(1) and 28 U.S.C. § 1391.

III. PARTIES

10. Plaintiff is a not-for-profit teaching hospital located in St. Paul, Minnesota. It furnishes hospital services under the Medicare program.

11. Donna E. Shalala is the Secretary of the Department of Health and Human Services, the federal department responsible for the administration of the Medicare program.

IV. GENERAL BACKGROUND

12. The Medicare statute establishes a system of health insurance for most individuals aged 65 or over, for disabled persons who meet certain qualifications, and for individuals suffering end-stage renal disease who meet certain qualifications. 42 U.S.C. § 1395c. Pursuant to 42 U.S.C. § 1395cc, plaintiff entered into a written agreement with defendant to provide hospital services to eligible individuals.

13. For cost reporting years beginning before October 1, 1983, the Medicare program reimbursed *all* hospital services on a "reasonable cost" basis. 42 U.S.C. § 1395f(b). Reasonable cost is defined as the "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, [to] be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services." 42 U.S.C. § 1395x(v)(1)(A).

14. In prescribing regulations to determine "reasonable cost," the Secretary is directed by 42 U.S.C. § 1395x(v)(1)(A) to take into account both the direct and indirect costs of providers of services; to consider, among other

things, the principles generally applied by national organizations or established pre-payment organizations in making third-party payments for medical care; and to ensure that "the necessary costs of efficiently delivering covered services to individuals covered by the [Medicare] program . . . will not be borne by individuals not so covered. . . ." Regulations have been issued by the Secretary to implement the reasonable cost provisions of the Medicare statute. *See* 42 C.F.R. arts 405, 413.

15. Allowable costs under the "cost reimbursement" system are generally apportioned to Medicare in accordance with a provider's Medicare utilization rate, *i.e.*, the proportion of a hospital's services used by Medicare patients. For instance, if a hospital furnished 30% of its services to Medicare patients, Medicare would reimburse approximately 30% of the hospital's allowable costs.

16. Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system to reimburse most hospitals for inpatient *operating* costs. However, Congress retained the "reasonable cost" reimbursement system for certain hospital costs, including outpatient, medical education, and capital costs.

17. The prospective payment system for operating costs provided for a four-year transition period during which payment was based in part on a hospital-specific rate. *See Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988). The hospital-specific rate was defined as each hospital's "allowable operating costs of inpatient hospital services [per discharge] . . . recognized under this title" for a base period, adjusted for inflation. 42 U.S.C. § 1395ww(b)(3)(A). After the transition period, payment under the prospective payment system for operating costs has been based on a national rate per Medicare discharge, subject to numerous adjustments. 42 U.S.C. § 1395ww(d).

V. THE MEDICARE CLAIMS AND APPEALS PROCESS

18. The Secretary has contracted out many of her audit and payment functions to organizations (usually insurance companies) known as fiscal intermediaries.

19. At the close of a fiscal year, a provider of services must submit to its intermediary a "cost report" showing both the costs incurred by it during the fiscal year and the appropriate share of those costs to be apportioned to Medicare. 42 C.F.R. §§ 413.20(b), 413.24(f). The intermediary is required to analyze and audit the cost report and inform the provider of a final notice of program reimbursement ("NPR"). 42 C.F.R. § 405.1803.

20. A provider dissatisfied with its intermediary's determination may file an appeal with an administrative body called the Provider Reimbursement Review Board ("PRRB" or "Board") within 180 days of the date of the NPR. Section 1878(a) of the Social Security Act ("the Act"), 42 U.S.C. § 1395oo(a).

21. The PRRB lacks the authority to rule on the validit of a Medicare regulation. It is legally required to comply with all of the Secretary's Medicare regulations. 42 C.F.R. § 405.1867; *Bethesda Hospital Association v. Bowen*, 108 S. Ct. 1255, 1259 (1988).

22. A provider that has filed an appeal with the Board may ask the Board to determine that it lacks the authority to decide "a question of law or regulations relevant to the matters in controversy." Section 1878(f)(1) of the Act (third and fourth sentences), 42 U.S.C. § 1395oo(f)(1). Such a request is generally known as an expedited judicial review ("EJR") petition.

23. If the Board determines that it lacks the authority to decide the issue raised by the provider in its EJR petition, a provider may obtain judicial review of that

issue by filing a court suit within sixty days of receipt of the Board's EJR determination. Section 1878(f)(1) of the Act (third sentence).

VI. THE GME PER RESIDENT AMOUNT PAYMENT METHODOLOGY

24. In 1986, Congress enacted section 1886(a) of the Act, 42 U.S.C. § 1395ww(h), which radically altered the Medicare payment methodology for graduate medical education costs. Pub. L. No. 99-272, § 9202. Effective with cost reporting years beginning on or after July 1, 1985, the new legislation provided that each hospital would be paid the reasonable cost per resident incurred in its base period (its cost reporting year beginning in federal fiscal year 1984), updated by an inflation factor and multiplied by the current number of full-time-equivalent residents. *Id.*

25. The GME per resident amount methodology in section 1886(h) of the Act is a prospective payment system, a fact obscured by the Secretary's implementation of the provision. Under the GME statute, payment for GME is no longer based on the "reasonable costs" incurred by a hospital during each cost reporting year, as in the past. Rather, a hospital's GME payment rate for a particular year is based on costs per resident incurred prior to the effective date of section 1886(h) of the Act. The GME per resident amount methodology is, in effect, a prospective payment system for GME that bases payment entirely on a hospital-specific rate instead of a national rate.

26. On September 29, 1989, the Secretary issued regulations to implement the new GME statute. 54 Fed. Reg. 40,287-40,321, adopting 42 C.F.R. § 413.86.

27. By that date, the Medicare intermediaries had already audited, and issued NPRs for, the year to be used as the GME base year for virtually all hospitals in the country. In many cases, an NPR had been issued for the

GME base year more than three years previously. Long-established Medicare regulations preclude the reopening of a Medicare cost report more than three years after issuance of the original NPR for a cost reporting year. *See* 42 C.F.R. § 405.1885(a); Provider Reimbursement Manual § 2931.1.A.; Intermediary Manual § 2631.1.A; PRRB Dec. No. 80-D12, *Community Health Services of Crawford County, Inc.*, CCH Medicare and Medicaid Guide ¶ 30,459 (1980).

28. Under "reasonable cost" principles, hospitals were entitled to claim physician services devoted to approved medical education programs as allowable GME costs. *See* 48 C.F.R. § 405.481. They were required to "[m]aintain the time records or other information . . . used to allocate physician compensation" in auditable form for a period of *"four years* after the end of each cost reporting period to which the allocation applies." 42 C.F.R. § 405.481(g)(1), (3) (emphasis added). By the time that the Secretary issued the GME per resident amount regulations, the four-year record retention period for the GME base year was over, and hospitals were no longer required to retain supporting documentation for that period.

29. Nonetheless, the Secretary's GME regulations do not direct the intermediaries to compute a hospital's payment amount under the GME per resident amount methodology by using the amount recognized as reasonable for direct graduate medical education costs in the hospital's audited base year cost report issued with the hospital's base year NPR. Rather, the regulations authorize the Medicare intermediaries to reaudit a hospital's base year. 42 C.F.R. § 413.86(e)(1)(ii). The preamble to the final rule states:

> We would like to assure all interested parties that no new reimbursement principles will be applied during the reaudit. Rather, our intent is to ensure that the

reimbursement principles in effect during the GME base year were correctly applied.

54 Fed. Reg. 40,301 (col. 2) (1989).

30. The regulations state that, if a hospital's cost report for its GME base year is no longer subject to reopening under 42 C.F.R. § 405.1885, the Medicare intermediary may apply the results of its reaudit *only* for purposes of the GME per resident amount methodology. 42 C.F.R. § 413.86(e)(1)(iii). The intermediary may not, in this instance, apply the results of the reaudit to the GME base year cost report itself. *Id.*; *see also* 54 Fed. Reg. 40,301 (1989). Accordingly, the regulations allow the Medicare intermediaries to compute payment under the GME per resident amount methodology using a reasonable cost determination for the GME base year that is different from the amount recognized as reasonable in the audited cost report for the GME base year itself.

31. Nowhere in the preamble to the final rule did the Secretary cite any language in section 1886(h) of the Act, or in the accompanying legislative history, that allows the Secretary to reaudit a hospital's base year cost report for purposes of the GME per resident amount methodology or that allows the Secretary to use a base year "reasonable cost" determination for purposes of the GME per resident amount methodology that deviates from the Secretary's "reasonable cost" GME determination for the base year itself.

32. Despite the assurance given by the Secretary in the preamble in the final GME per resident amount regulation (quoted above), the Secretary did not simply tell the Medicare intermediaries to reaudit the GME base year using the same reimbursement principles in effect during that year (*i.e.*, during federal fiscal year 1984). Instead, in 1990, the Secretary issued a 24-page, single-spaced set of instructions that specify the standards that the Medicare intermediaries were to use in reauditing the base years. In addition, also in 1990, the Secretary issued a 34-page, single-spaced set of questions and answers to be applied

by the intermediaries in their reaudits. The Secretary's reaudit instructions and questions and answers adopted harsh new standards not in effect during the GME base year itself. Consequently, in virtually all cases, the intermediaries' "reasonable cost" determinations in the reaudits of the GME base year performed for purposes of the GME per resident amount methodology were significantly lower than the determinations in the audit done for the base years themselves.

33. The Medicare GME per resident amount regulations required the Medicare intermediaries, after completing their reaudits, to issue to each hospital a notice of "its base-period average per resident amount." 42 C.F.R. § 413.86(e)(1)(v). Hospitals have 180 days from the date of this notice to file an appeal with the PRRB. *Id.*

34. Plaintiff does not object to the Secretary applying the GME per resident amount methodology to its cost reporting years beginning on or after July 1, 1985. However, plaintiff does object to the Secretary doing so by using the reasonable cost determination from the GME reaudit. Plaintiff contends that the Secretary is legally required to use the reasonable cost determination from the *final* audit applicable to the GME base year itself.

VII. FACTS SPECIFIC TO THE PLAINTIFF

35. Plaintiff's GME base year is its fiscal year ending December 31, 1984. The hospital's Medicare intermediary audited that year and subsequently issued an NPR on February 28, 1986.

36. Three years passed after issuance of the NPR for plaintiff's 1984 cost reporting year without a reopening related to medical education costs. Accordingly, as of March 1, 1989 (three years and one day after issuance of the NPR), the Secretary's reopening regulations prohibited the Secretary from reopening plaintiff's 1984 cost report. 42 C.F.R. § 405.1885.

37. Plaintiff's GME base year closed on December 31, 1984. Accordingly, as of January 1, 1989 (four years

and one day later), the hospital was no longer even legally required to retain the physician allocation documentation supporting the GME claims in its GME cost report. *See* 42 C.F.R. § 405.481(g)(1), (3).

38. Notwithstanding the facts recited in the previous two paragraphs, plaintiff's Medicare intermediary began reauditing plaintiff's base year in late 1990 for purposes of the GME per resident amount methodology. On February 18, 1991, the intermediary issued a notice of average per resident amount for the hospital's base year. The intermediary determined therein that the hospital's allowable GME base year costs under "reasonable cost" principles were $5,412,686—an amount that is significantly lower than its determination in the final audit for fiscal year 1984 itself. As a result of the intermediary's determination, the hospital's Medicare reimbursement for its graduate medical education costs has been, and continues to be, substantially less than the amount to which it is entitled for its 1986 and all subsequent cost reporting years.

39. Consistent with 42 C.F.R. § 413.86(e)(1)(iii), the hospital's Medicare intermediary has not attempted to apply the reaudit results directly to plaintiff's base year (its 1984 fiscal year). Plaintiff's GME payment for the base year continues to be based on the "reasonable cost" determination in the base year audit completed in February 1986 rather than the "reasonable cost" determination in the 1991 reaudit. However, the Medicare intermediary has used, and continues to use, the 1991 reaudit determination (rather than the 1986 determination applicable to the base year itself) to apply the GME per resident amount methodology to plaintiff's 1986 and subsequent cost reporting years.

40. Plaintiff timely appealed the intermediary's notice of average per resident amount to the PRRB. Plaintiff's appeal challenged, among other things, the legality of the Secretary's reaudit regulations. Plaintiff contended that where (as here) the GME base year is no longer subject

to reopening, the intermediary must apply the determination of allowable GME costs in the audited GME base year cost report in determining the per resident amount under section 1886(h) of the Act. Plaintiff contended that the Secretary's GME regulations are invalid to the extent that they permit a determination of allowable GME base year costs for purposes of the per resident amount mehodology under section 1886(h) of the Act that deviates from the determination of allowable GME costs in the final, audited cost report for the base year itself.

41. Plaintiff filed an EJR petition under section 1878(f)(1) of the Act asking the Board to determine that it lacks the authority to decide the validity of the Secretary's reaudit regulations. By letter dated September 28, 1994, the Board determined that it did not have the authority to decide the validity of the Secretary's reaudit regulations. Accordingly, the Board granted plaintiff permission to seek judicial review of this issue.

42. Plaintiff received the Board's "EJR determination" on October 3, 1994. Accordingly, this suit is timely filed within 60 days of the date on which plaintiff received the Board's EJR determination.

VIII. INVALIDITY OF SECRETARY'S REAUDIT REGULATION

43. The Secretary's GME reaudit regulation is invalid because it conflicts with the Medicare statute. Section 1886(h)(2)(A) of the Act requires the Secretary to use as the numerator in the GME per resident amount methodology the "amount recognized as reasonable under this title for direct graduate medical education costs of the hospital" in the base year. However, the Secretary's regulation allows the intermediary to use an entirely different amount as the numerator in the formula, and the intermediary has, in fact, done so in this case. Where, as here, the "amount recognized as reasonable under this title for direct graduate medical education costs" in the

base year is *final* (*i.e.*, no longer subject to reopening), the Secretary is legally bound to use that "amount" for purposes of the GME per resident amount methodology.

44. The Secretary's reaudit regulation is also invalid because it is a retroactive rule. It is well-established that an administrative agency may not issue a retroactive rule unless it has express statutory authority to do so. *Bowen v. Georgetown University Hospital*, 109 U.S. 468 (1988). It is also well-established that the general rulemaking provisions in the Medicare statute do not authorize the Secretary to issue retroactive rules. *Id.* There is nothing in section 1886(h) of the Act that would authorize the Secretary to issue a retroactive rule to upset the reopening standards and the document-retention standards in effect at the time of the GME statute's enactment.

45. The Secretary's reaudit regulation is also invalid because it is arbitrary and capricious. The Secretary has previously recognized that rates under a prospective payment system must be set as quickly as possible. Yet, even though the GME per resident amount methodology is a prospective payment system, the Secretary waited three and a half years after enactment of section 1886(h) of the Act to issue regulations and then waited an additional year and a half to conduct and complete reaudits. In those reaudits, the Secretary used more rigorous standards than were in effect during the base year itself. Moreover, the reaudits were conducted at a time when the base year cost reports were no longer subject to reopening, when hospitals were no longer legally required to retain the base year documentation necessary for an audit, and when, for many hospitals, the financial personnel who were at the hospital during the GME base year were no longer employed by the hospital. The Secretary's tactics have caused great prejudice and distress to many hospitals, including plaintiff.

46. The Secretary's reaudit regulation is also otherwise contrary to law.

IX. REQUESTED RELIEF

WHEREFORE, plaintiff requests:

(1) A declaration that the Secretary's reaudit regulation is invalid;

(2) A declaration that the Secretary must use the final GME "reasonable cost" determination applicable to the GME base year itself in applying the per resident amount methodology of section 1886(h) of the Act;

(3) An order requiring that, to the extent that the Secretary has made (or has recouped) payment under the GME per resident amount methodology prior to decision in this case, the Secretary recompute plaintiff's entitlement in accordance with the preceding subparagraph and, within sixty days of the date of the court judgment, pay plaintiff the additional amounts due, plus interest in accordance with 42 U.S.C. § 1395oo(f)(2);

(4) An order requiring the Secretary to act in accordance with subparagraph (2) above in computing all future payments under the GME per resident amount methodology;

(5) Legal fees and costs of suit incurred by plaintiff; and

(6) Such other relief as this Court deems just and appropriate.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

(Title Omitted)

ANSWER

Donna E. Shalala, Secretary of Health and Human Services [the "Secretary"], defendant, answers the complaint as follows:

FIRST DEFENSE

Plaintiff has failed to state a claim upon which relief can be granted.

SECOND DEFENSE

With respect to the following corresponding numbered paragraphs of the complaint:

1. This paragraph characterizes the lawsuit from plaintiff's perspective, and no answer is required. However, if an answer be deemed necessary, deny.

2. Admit.

3. Admit the first sentence and the second sentence, except to deny that the audit was necessarily a "*final*" audit. Deny the third sentence.

4. Deny, except to admit that final regulations implementing the GME statute were issued in September, 1989.

5. Admit the first sentence. Deny the second sentence. Admit the remaining sentences, except to deny the allegation that the determination of plaintiff's allowable GME base year costs was a determination made "[n]ot surprisingly under all these circumstances."

6. This paragraph recites plaintiff's legal contention as to which no answer is required. However, if an answer is deemed necessary, deny.

7. Admit.

8. Deny, except to admit the Court has jurisdiction under 42 U.S.C. 1395oo(f)(1).

9. Admit.

10. Admit.

11. Admit.

12. Admit.

13. Admit.

14. Admit that the cited statutory and regulatory provisions say what they say, and the Court is respectfully referred to those provisions for a full statement of their contents. Otherwise, deny.

15. Admit this is a generally accurate statement of the "cost reimbursement" system. Otherwise, deny.

16. Admit.

17. Admit.

18. Admit.

19. Admit.

20. Admit.

21. Admit.

22. Admit.

23. Admit.

24. Admit that the cited statutory provisions say what they say, and the Court is respectfully referred to those provisions for a full statement of their contents. Otherwise, deny.

25. Deny, except to admit the second and third sentences.

26. Admit.

27. Admit the first sentences, except the allegation that these actions had been taken for "virtually all" hospitals. Admit the second sentence. Deny the third sentence, except to admit that the cited regulations and case say what they say, and the Court is respectfully referred to the regulations and the case report for a full statement of their contents.

28. Admit the first and second sentences. Deny the third sentence.

29. Admit that the regulations do not require the intermediaries to compute a hospital's payment amount under the GME per resident amount methodology solely on the basis of the amount recognized as reasonable in the hospital's base year cost report issued with the hospital's base year NPR; admit that the regulations authorize the Medicare intermediaries to reaudit a hospital's base year; and admit that the preamble to the rule contains the quoted language. Otherwise, deny.

30. Admit the regulations say what they say, and the Court is respectfully referred to those regulations for a full statement of their contents. Otherwise, deny.

31. Admit the preamble to the rule says what it says, and does not say what it does not say. Otherwise, deny.

32. Deny, except to admit the portion of the second sentence following the word "[i]nstead," and to admit the third sentence.

33. Admit.

34. This paragraph contains plaintiff's contentions and legal positions, as to which no answer is required. However, if an answer is deemed required, deny.

35. Admit.

36. Admit the first sentence. Deny the second sentence.

37. Admit.

38. Admit, except to deny the first clause of the first sentence and to deny the last sentence.

39. Admit.

40. Admit the first sentence. The remaining sentences contain plaintiff's legal contentions as to which no answer is required, but if an answer is deemed required, deny.

41. Admit.

42. Admit.

43. Deny.

44. Deny.

45. Deny.

46. Deny.

Defendant denies that plaintiff is entitled to the relief it requests in Part IX of the complaint, or to any relief.

Defendant specifically denies each and every allegation to which an answer has not previously been given.

Having answered the complaint, defendant requests that the Court enter judgment in her behalf, and grant defendant such other and further relief as may be appropriate and just.

Excerpts from 54 FED. REG. 40,315-40,319 (1989)*

§ 412.113. Payments determined on a reasonable cost basis.

* * * *

(b) *Direct medical education costs.* (1) Payment for the direct medical education costs of interns and residents in approved programs for cost reporting periods beginning prior to July 1, 1985, and for approved education activities of nurses and paramedical health professionals is made as described in § 413.85 of this chapter.

(2) For cost reporting periods beginning on or after July 1, 1985, payment for the direct medical education costs of interns and residents in approved programs is made as described in § 413.86 of this chapter.

(3) Except as provided in § 413.86(c)(1) of this chapter, for cost reporting periods during the prospective payment transition period, the costs of medical education must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate as provided in subpart E of this part.

§ 413.86 Direct graduate medical education payments.

(a) *Statutory basis and scope*—(1) *Basis.* This section implements section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section applies to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

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* Includes correction of technical errors in 55 Fed. Reg. 299 (1990).

(b) *Definitions.* For purposes of this section, the following definitions apply:

"Approved geriatric program" means a fellowship program of one or more years in length that is approved by the Accreditation Council for Graduate Medical Education (ACGME) under the ACGME's criteria for geriatric fellowship programs in internal medicine and family practice.

"Approved medical residency program" means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 405.522(a) of this chapter.

(2) May count towards ceritification of the participant in a specialty or subspecialty listed in the *Directory of Residency Training Programs* published by the American Medical Association.

(3) Is approved by the Accreditation Council For Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

"Base period" means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

"CPI—U" stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

"Foreign medical graduate" means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

"*FMGEMS*" stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

"*FTE*" stands for full-time equivalent.

"*Medicare patient load*" means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

"*Resident*" means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required by the order to become certified by the appropriate specialty board.

(c) *Payment for graduate medical education costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved graduate medical education programs as described in paragraph (d) through (h) of this section.

(d) *Calculating payment for graduate medical education costs.* A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(1) *Step one.* The hospital's updated per resident amount (as determined under paragraph (e) of this section) is multiplied by the actual number of FTE residents (as determined under paragraph (g) of this section). This result is the aggregate approved amount for the cost reporting period.

(2) *Step two.* The product derived in step one is multiplied by the hospital's Medicare patient load.

(3) *Step three.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part as determined through the Medicare cost report.

(e) *Determining per resident amounts for the base period*—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, in-

cluding those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(1) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(2) *For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) If a hospital's base period began on or after October 1, 1983 and before July 1, 1984, the amount is adjusted

by the percentage change in the CPI—U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this action apply. The adjusted amount is then increased by one percent.

(ii) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(3) *For cost reporting periods beginning on or after July 1, 1986.* For cost reporting periods beginning on or after July 1, 1986, each hospital's per resident amount for the previous cost reporting period is adjusted by the projected change in the CPI—U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI—U that occurred during the cost reporting period.

(4) *Exceptions*—(i) *Base period for certain hospitals.* If a hopsital did not have any approved medical residency training programs or did not particpate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the following:

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of

this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the intermediary must contact HCFA Central Office for a determination of the appropriate amount to use.

(ii) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects graduate medical education costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(iii) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact HCFA Central Office to receive a special CPI—U adjustment factor.

(f) *Determining the total number of FTE residents.* (1) Subject to the weighing factors in paragraphs (g) and (h) of this section, the count of FTE residents is determined as follows:

(i) Residents in an approved program working in all areas of the hospital complex may be counted.

(ii) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital or, except as provided in paragraph (f)(1)(iii) of this section, in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of time worked as compared to the average time spent by other residents working in the same specialty program.

(iii) On or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:

(A) The resident spends his or her time in patient care activities.

(B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(2) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information.

The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(i) The name and social security number of the resident.

(ii) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(iii) The dates the resident is assigned to the hospital and any hospital-based providers.

(iv) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(v) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(vi) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of paragraph (h) of this section.

(vii) The name of the employer paying the resident's salary.

(g) *Determining the weighted number of FTE residents.* Subject to the provisions in paragraph (h) of this section, HCFA determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(1) For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year. An initial residency period may not exceed five years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to two additional years.

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)1)(iii) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the 1985-1986 Directory of Residency Training Programs.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 405.522(a) of this chapter.

(iii) For residency programs in geriatric medicine approved by the ACGME, as set forth in later editions of the directory specified in paragraph (g)(1)(ii) of this section, these programs are considered approved programs retroactively to the latter of—

(A) The starting date of the program within a hospital; or

(B) The hospital's costs reporting period beginning on or after July 1, 1985.

(iv) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in paragraph (b) of this section, is counted toward the initial residency period limitation.

(2) If the resident is in an initial residency period, the weighting factor is one.

(3) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987 and is .50 thereafter without regard to the hospital's cost reporting period.

(h) *Determination of weighting factors for foreign medical graduates.* (1) The weighing factor for a foreign medical graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate—

(i) Has passed FMGEMS; or

(ii) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(2) Before July 1, 1986, the weighting factor for a foreign graduate is 1.0 times the weight determined under the provisions of paragraph (g) of this section. On or before July 1, 1986 and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (h)(1) of this section is .50 times the weight determined under the provisions of paragraph (g) of this section.

(3) On or after July 1, 1987, these foreign medical graduates are not counted in determing the number of FTE residents.

(4) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of paragraph (g) of this section for the part of the cost reporting period beginning with the month the resident passes the test.

(5) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section.

(i) *Special rules for States that formerly had a waiver from Medicare reimbursement principles.* (1) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222 (a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(2) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(3) Per resident amounts are determined for the base period and updated as described in paragraph (e) of this section. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in paragraph (d) of this section.

(j) *Adjustment of a hospital's target amount or prospective payment hospital-specific rate*—(1) *Misclassified*

operating costs—(i) *General rule.* If a hospital has its base-period graduate medical education costs reduced under paragraph (e)(1) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its rate of increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(2) *Misclassification of graduate medical education costs*—(i) *General rule.* If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate medical education costs in the graduate medical education base period,

the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(A)

No. 96-1375

Supreme Court, U.S.
FILED
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CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Whether a provision (42 U.S.C. § 1395ww(h)(2)(A)) in 1986 legislation establishing a new Medicare payment methodology for graduate medical education ("GME") costs, which directs the Secretary of Health and Human Services ("the Secretary") to "determine," for a hospital's 1984 cost reporting year, "the average amount [of the hospital's GME costs] recognized as reasonable under this subchapter . . . for each full-time-equivalent resident," requires the Secretary to determine the average using the actual, final "amount recognized as reasonable under this subchapter" for 1984 or whether it authorizes the Secretary to determine the average by reauditing and redetermining the amount of GME costs for 1984 after the reopening and record retention periods for 1984 have expired.

PARTIES TO THE PROCEEDINGS

Petitioner is St. Paul-Ramsey Medical Center, Inc., a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner does not have a parent or any non-wholly owned subsidiaries.

Respondent is Donna E. Shalala, Secretary of the Department of Health and Human Services.

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OCTOBER TERM, 1997

No. 96-1375

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Petition Appendix ("Pet. App.") 1a-3a) is reported at 91 F.3d 57. The opinion of the district court (Pet. App. 4a-8a) is unreported.

JURISDICTION

The court of appeals entered its judgment on July 26, 1996. Pet. App. 1a. It denied petitioner's petition for rehearing on September 30, 1996. Pet. App. 9a. Justice Thomas granted two extensions of time for filing a writ of certiorari in this case, the second of which extended the time to and including February 27, 1997. Petitioner filed its petition for certiorari on February 27, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395ww(h)(2)(A) provides: "The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." So that the Court may review the provision in context, 42 U.S.C. § 1395ww(h) is reproduced in its entirety in the Appendix. In addition, relevant portions of the following are reproduced in the appendix: 42 U.S.C. § 1395oo; 42 U.S.C. §§ 1395ww(a)(1)(C), (a)(4), (b)(3)(A); 42 C.F.R. §§ 405.481(g) (1985), 405.1801(a)(1) (1985), 405.1803(a) (1985), 405.1807 (1985), 405.1885(a) (1985), 412.71(d) (1985), 412.113(b) (1985), and 413.86(e)(1).

STATEMENT

This case presents a straightforward question of statutory construction. At issue is the meaning of a provision in 1986 legislation establishing a new Medicare payment method for graduate medical education ("GME") costs effective for hospital fiscal years beginning on or after July 1, 1985. For all previous years, Medicare had reimbursed teaching hospitals its share of the "reasonable costs" of GME. Under the new method, each year Medicare pays a teaching hospital a percentage, based on the ratio of Medicare patient days to total patient days, of a base year (1984) amount per intern and resident (updated for inflation) multiplied by the hospital's number of full-time-equivalent ("FTE") interns and residents ("residents") during the payment year.

With respect to the base year amount per resident, the statute directs the Secretary to "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education

costs of the hospital for each full-time-equivalent resident." When the GME statute was enacted in 1986, a long-standing administrative process to establish the amount of GME costs recognized as reasonable for each year, including 1984, had already been established under the Medicare subchapter. Thus, to determine the "average" base year amount per resident under the new payment method, the Secretary had to count the number of FTE residents at the hospital during 1984 and divide the amount of GME costs recognized as reasonable for the hospital for 1984 under the existing process by the number of the hospital's 1984 residents.

By April 1986, when the GME legislation was enacted, the Secretary had issued determinations, under the long-standing administrative process, of the amount of reasonable GME costs for 1984 for some hospitals but not for others. In no case, however, was the determination of the amount of reasonable GME costs for 1984 yet final and binding under the Secretary's rules. All such determinations were still well within the three-year reopening period established under the Secretary's regulations and were subject to revision, if necessary, during that period.

The Secretary waited until September 29, 1989, three and a half years after the statute's enactment, to issue regulations. By that date, many of the determinations of the amount of reasonable GME cost for 1984 (including the determination issued to petitioner) were final, binding, and no longer subject to reopening under the Secretary's own rules, and teaching hospitals were no longer even required to retain audit documentation for 1984 under those rules. Nonetheless, the Secretary issued a regulation (the "reaudit regulation") requiring *reaudits* of the 1984 GME costs recognized as reasonable for those teaching hospitals for purposes of determining their average base year amounts per resident. Thus, for purposes of the new GME payment methodology, the Secretary retroactively abrogated the reopening and record retention standards in her own regulations after expiration of the applicable

limitations periods and placed hospitals in the position of having to reprove costs already proven with finality at a time when many no longer possessed the necessary audit documentation for 1984.

Petitioner challenges the validity of the reaudit regulation. Petiitoner contends that in computing "the average" base year amount per resident under the GME legislation, the Secretary must, under the plain words of the statute, use as the numerator the actual amount of GME costs "recognized as reasonable" under the Medicare subchapter for 1984. The Secretary contends that the statute is "ambiguous" and the purported ambiguity allows her to reopen "final and binding" 1984 audit determinations and reaudit 1984 costs for purposes of establishing the 1984 cost per resident under the GME legislation.

A. Statutory and Regulatory Background.

1. In 1965, Congress enacted the Medicare program primarily to furnish health insurance for the elderly. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a). From then until 1983, the Medicare program reimbursed participating hospitals its share of the "reasonable cost" incurred in furnishing inpatient hospital services to Medicare patients.[1] 42 U.S.C. § 1395f(b).

[1] The Social Security Amendments of 1965 created two separate insurance programs for Medicare beneficiaries, the Hospital Insurance Benefits program established under part A of title XVIII of the Social Security Act, *see* 42 U.S.C. §§ 426 & 1395c-1395i-4, and the Supplementary Medical Insurance program established under part B of title XVIII, *see* 42 U.S.C. §§ 1395j-1395w-4(j). Part A covers certain "provider" (*i.e.*, institutional) services, including inpatient hospital services. 42 U.S.C. § 1395d(a)(1). The Medicare program has historically paid for these services on a "reasonable cost" basis, "as determined under section 1395x(v)," except in those cases in which a provider's "reasonable costs" exceeded its customary charges. 42 U.S.C. § 1395f(b). Part B generally covers "medical and other health services," 42 U.S.C. § 1395k(a), including phyiscians' services, 42 U.S.C. 1395x(s)(1) (defining "medical and other health services"). The Medicare program has historically paid for these services on a "reasonable charge" basis. 42 U.S.C. § 1395*l*(a).

Hospitals furnishing inpatient hospital services under Medicare received reimbursement for three types of cost: operating, capital, and education. The most significant education costs were the costs incurred for the services furnished by residents in approved training programs, known as GME costs.[2] GME costs included the residents' stipends, teaching physician compensation attributable to the training of residents in approved programs, and support and space costs related to the residency programs. 42 C.F.R. § 405.421(g) (1985) (currently 42 C.F.R. § 413.85(g)). Teaching physician compensation cost was classified as GME cost or operating cost based on physician allocation agreements and supporting records reflect-

[2] Residents in approved GME programs have graduated from medical school and are generally licensed to practice medicine. Ordinarily, physician services are excluded from "inpatient hospital services" under part A, 42 U.S.C. § 1395x(b)(4), and reimbursed under part B, 42 U.S.C. § 1395x(q). However, the services furnished by "an intern or a resident-in-training" in approved teaching programs are included within the definition of "inpatient hospital services," 42 U.S.C. § 1395x(b)(6), and excluded from the definition of "physicians' services," 42 U.S.C. § 1395x(q). Thus, Medicare has always reimbursed the services of residents in approved programs as inpatient hospital services under part A, even though the services of residents in unapproved programs are reimbursed as physician services under part B.

The Medicare statute provides that reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs" and mandates that both "direct and indirect costs" be taken into account. 42 U.S.C. § 1395x(v)(1)(A). Accordingly, since the inception of the Medicare program, the net cost of approved GME programs has been reported in hospital cost reports pursuant to procedural requirements established in the regulations now codified at 42 C.F.R. §§ 413.1 and 413.20, and has been included in Medicare's determinations of the reasonable cost of inpatient hospital services, *see* 42 C.F.R. § 405.1803, pursuant to the substantive standards established in the regulation now codified at 42 C.F.R. § 413.85.

ing the proportion of physicians' time attributable to residency training programs and the proportion of time attributable to general services furnished to the hospital. 42 C.F.R. § 405.481 (1985). Hospitals were required to retain teaching physician allocation agreements and supporting records for a period of four years after the end of a cost reporting period. *Id.* § 405.481(g) (1985).

2. The Secretary follows a long-established procedure for recognizing costs as reasonable for each cost reporting year. At the close of a year, a hospital participating in the Medicare program, commonly referred to as a "provider," files a cost report with its Medicare fiscal intermediary (the Secretary's agent), which audits the cost report and issues a determination of the hospital's reasonable costs in a notice of program reimbursement ("NPR"). 42 U.S.C. § 1395h; 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. § 413.20; 42 C.F.R. § 405.1803(a)(1); *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 400-01 (1988). A provider dissatisfied with the intermediary's determination may appeal to the Provider Reimbursement Review Board ("PRRB" or "Board") and eventually file a court suit. 42 U.S.C. §§ 1395oo(a), (f)(1).

The intermediary's "findings on matters at issue" in an NPR are subject to reopening for a period of three years. 42 C.F.R. § 405.1885(a). Except in cases of fraud, no intermediary finding on the matters at issue in an NPR "may be reopened after such 3-year period." *Id.* If the provider does not appeal and a reopening has not been effected within the three-year period, the intermediary's determination is "final and binding." 42 C.F.R. § 405.1807.

3. Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system ("PPS") to reimburse most hospitals for inpatient *operating* costs. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e) (enacting 42 U.S.C.

§ 1395ww(d)). PPS does not apply to capital costs or education costs, both of which continued to be reimbursed under "reasonable cost" payment principles. 42 U.S.C. § 1395ww(d)(1)(A) (incorporating the definition of "operating costs of inpatient hospital services" in 42 U.S.C. § 1395ww(a)(4)).

For the first four years of PPS (1984-1987), Medicare paid hospitals a blend of two rates for operating costs—the "hospital-specific rate" and the "federal rate." *Georgetown Univ. Hosp. v. Bowen*, 698 F. Supp. 290, 292-93 (D.D.C. 1987), *aff'd*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"); 42 U.S.C. § 1395ww(d)(1)(A)(i)-(ii); 42 C.F.R § 412.70 (1991). The hospital-specific rate was established for each hospital based on the hospital's operating costs "recognized under this subchapter" for the PPS base year (1982) per patient discharge. 42 U.S.C. §§ 1395ww(d)(1)(A)(i)(I), (ii)(I) (incorporating 42 U.S.C. § 1395ww(b)(3)(A)); 42 C.F.R. § 412.73(a) (1996). The federal rate was an amount per patient discharge based on average national and regional costs during a base year. 42 U.S.C. § 1395ww(d)(1)(A)(i)(II), (ii)(II); 42 U.S.C. § 1395ww(d)(3). Since 1988, hospitals have been paid for operating costs solely on the basis of the federal rate. *Georgetown II*, 698 F. Supp. at 292; 42 U.S.C. § 1395ww(d)(1)(A)(iii).

The Secretary's PPS regulations provided that the hospital-specific rate is "final, and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983" except in very limited circumstances. 42 C.F.R. § 405.474(b)(1)(v) (1983); 42 C.F.R. § 412.71(d) (1985). They also included what is commonly known as the "consistency rule," which specified that the characterization of costs (*i.e.*, operating or medical education) established for the PPS hospital-specific rate must also be used for future years. 42 C.F.R. § 405.477(c)(2) (1983); 42 C.F.R. § 412.113(b) (1985).

4. In 1985, the Secretary issued a regulation which purported to freeze medical education payments for one year at 1984 levels. Under the Secretary's regulation, a hospital's medical education reimbursement for its first cost reporting year beginning on or after July 1, 1985 would have been the lower of its allowable medical education costs for that year or for its cost reporting year beginning in fiscal year 1984 (the base year). 42 C.F.R. § 405.421(a)(2)(i) (1985); 50 Fed. Reg. 27,732 (1985). In the accompanying preamble, the Secretary made clear that the final determination of allowable base year costs for the base year itself would also be used for purposes of the freeze. 50 Fed. Reg. 27,726 (1985).

In April 1986, Congress repealed the Secretary's freeze and adopted a new GME payment methodology (effective for cost reporting years beginning on or after July 1, 1985), based, like the Secretary's regulation, on a hospital's GME costs during fiscal year 1984. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9202. The statute directed the Secretary to calculate an "average" for each hospital. 42 U.S.C. § 1395ww(h)(2)(A). This was to be done by dividing the hospital's GME costs "recognized as reasonable under this subchapter" for 1984 by the hospital's number of residents in 1984. *Id.* For a year subject to the new method, Medicare pays a percentage, based on Medicare patient days to total patient days, of the base year amount per resident adjusted for inflation times the hospital's number of residents during the year.[8] 42 U.S.C. § 1395ww(h).

When the GME legislation was enacted, there were as yet no final and binding determinations of the amount

[8] For instance, if in 1996 a hospital's adjusted base year amount per resident was $60,000, its number of residents was 10, and its Medicare patient load (*i.e.*, Medicare patient days to total patient days) was 25%, Medicare would reimburse the hospital $150,000 ($60,000 x 10 x 25%) for GME.

recognized as reasonable for 1984. In some cases, the Medicare intermediaries had not yet issued NPRs for 1984. In other cases, they had done so, but only shortly before the legislation was enacted. Thus, even where NPRs had been issued, they were still subject to reopening for nearly three years. In addition, hospitals in all cases were still subject to the record retention requirements for the 1984 cost reporting year.

5. On September 29, 1989, the Secretary issued regulations to implement the GME statute. 54 Fed. Reg. 40,286-321, adopting 42 C.F.R. § 413.86, Joint Appendix ("J.A.") 26-38. By that date, the NPR for 1984 had been issued in many cases more than three years earlier. Consequently, in those cases, the amount of GME costs recognized as reasonable in the NPR for 1984 was final, binding, and no longer subject to reopening. 42 C.F.R. §§ 405.1807, 405.1885(a). In addition, by that date hospitals were no longer required to retain the time records necessary for an audit of 1984 GME costs. 42 C.F.R. § 405.481(g)(3) (1995).

Nonetheless, the Secretary did not instruct the intermediaries to use the 1984 GME costs already recognized as reasonable in the normal audit and review process to determine the "average" GME base year amount per resident. Instead, the Secretary issued the reaudit regulation, which directed the intermediaries to reaudit a hospital's 1984 year to redetermine the 1984 GME costs to be used for the GME amount per resident calculation. 42 C.F.R. § 413.86(e)(1)(ii)-(iii).

The regulations state that, if a hospital's cost report for 1984 is no longer subject to reopening under 42 C.F.R. § 405.1885, the Medicare intermediary may apply the reaudited 1984 cost determination *only* for purposes of the GME amount per resident methodology. 42 C.F.R. § 413.86(e)(1)(iii). The intermediary may not, in this instance, use the reaudited 1984 cost determination to

change a hospital's Medicare reimbursement for 1984, which continues to be based on the amount recognized as reasonable in the final NPR for 1984. Thus, in cases where the 1984 reopening period had expired, the regulations authorized the intermediary to determine the average base year amount per resident under 42 U.S.C. § 1395ww(h)(2)(A) by using as the numerator a 1984 GME amount that is different from the amount actually recognized as reasonable for 1984 under the Medicare subchapter. The reaudit regulation retroactively abrogated, for purposes of the GME amount per resident methodology, the Secretary's long-standing reopening regulation, which precluded any reaudit of closed 1984 years.

In the preamble to the reaudit regulations, the Secretary "assure[d] all interested parties that no new reimbursement principles will be applied in the reaudit." 54 Fed. Reg. 40,301 (1989). In fact, however, the Secretary's reaudit regulations themselves made changes to the reimbursement principles in effect in 1984. While affirming the applicability of the consistency rule for an audit of 1984 used to establish GME payment for 1984, the Secretary provided that the consistency rule would not apply to the reaudit of 1984 used to establish 1984 GME costs for purposes of the GME base year amount per resident. 42 C.F.R. § 412.113(b)(3); 42 C.F.R. § 413.86(e)(1)(ii)(B)-(C); 54 Fed. Reg. 40,315-17 (1989), J.A. 26, 29-30.

The Secretary also retroactively amended her regulations governing finality of the PPS hospital-specific rate. She authorized hospitals affected by a reclassification of costs (from GME to operating or vice versa) in the GME reaudit to seek a conforming reclassification for purposes of the hospital-specific rate for PPS years still within the three-year reopening period. 42 C.F.R. § 413.86(j); 54 Fed. Reg. 40,318-19 (1989), J.A. 36-38. She declined,

however, to allow any conforming adjustments to the PPS federal rate. 54 Fed. Reg. 40,301 (1989).

In 1990, the Secretary issued a *Federal Register* notice acknowledging the problem of non-existent records stemming from expiration of the four-year record retention period for 1984. 55 Fed. Reg. 36,063-64 (1990). Specifically, the Secretary noted:

> [C]onsidering the retroactive effect of the change in GME payment policy for cost reporting periods beginning on or after July 1, 1985, we now find that physician allocation agreements, time records and other information may no longer exist for [1984] . . . because the record retention requirements specified in [42 C.F.R.] § 405.481(g) only require the retention of each physician compensation allocation for four years after the end of each cost reporting period to which the allocation applies.

Id. at 36,063. In these instances, the Secretary authorized the intermediaries to use physician time records from a year after 1984, or to use the results of a current three-week time study, for purposes of the 1984 reaudit. *Id.* The intermediaries were directed to use the physician allocation percentages derived from the audit of the later-year time records unless they were higher than the percentages recognized in the NPR for 1984, in which case the intermediaries were to use the lower physician allocation percentages from the 1984 NPR. *Id.*

B. Factual and Procedural History of This Case.

1. Petitioner is a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner's GME base year is its cost reporting year ending December 31, 1984. J.A. 17, ¶ 35, & 24, ¶ 35. After conducting a full audit, the Medicare intermediary issued the NPR for petitioner's 1984 fiscal year on February 28, 1986. *Id.*

Three years passed after issuance of petitioner's NPR for 1984 without a reopening related to medical educa-

tion costs or the issuance of regulations implementing the GME legislation. J.A. 17, ¶ 36, & 25, ¶ 36. Accordingly, as of March 1, 1989 (three years and one day after issuance of the NPR), the intermediary's determination of the amount recognized as reasonable for 1984 was "final and binding" and no longer subject to reopening. 42 C.F.R. §§ 405.1807, 405.1885(a). Moreover, as of January 1, 1989 (four years and one day after the close of its GME base year), petitioner was no longer required to retain the physician allocation documentation supporting the GME costs recognized as reasonable in the NPR for 1984. *See* 42 C.F.R. § 405.481(g)(1), (3) (1995); J.A. 17-18, ¶ 37, & 25, ¶37.

The Medicare intermediary nonetheless began reauditing petitioner's 1984 year in late 1990 for purposes of the GME amount per resident methodology. J.A. 18, ¶ 38, & 25, ¶ 38. On February 18, 1991, the intermediary issued a notice of average amount per resident for petitioner's 1984 year. *Id.* The intermediary computed the average amount per resident in that notice by using as the numerator a "reaudited" amount of 1984 GME costs which was lower than the amount recognized as reasonable in the NPR for 1984. *Id.* The Medicare intermediary has used this amount per resident—based on the *1991* reaudit determination of 1984 GME costs, rather than the determination in the NPR for 1984—to reimburse petitioner under the amount per resident methodology for all cost reporting years beginning on or after July 1, 1985.

Petitioner timely appealed the intermediary's notice of average amount per resident to the PRRB. J.A. 18, ¶ 40, & 25, ¶ 40. Petitioner challenged the legality of the Secretary's reaudit regulation, contending that the Secretary must use the amount of GME costs actually recognized as reasonable for 1984 through the normal audit and review process (rather than the reaudit amount)

to determine the average base year amount per resident under the new methodology.

The PRRB ruled that it lacks the authority to decide the validity of the reaudit regulation, thereby allowing petitioner to file a court suit challenging the validity of the regulation.[4] J.A. 19, ¶ 41, & 25, ¶ 41. Petitioner timely filed suit in the U.S. District Court for the District of Minnesota within the period allowed by the Medicare statute. J.A. 19, ¶ 42, & 25, ¶ 42.

2. On August 8, 1995, the district court issued a short opinion upholding the validity of the reaudit regulation. Pet. App. 4a-8a. The court relied on the reasoning in *Administrators of the Tulane Educational Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994) ["*Tulane*"], and *Toledo Hospital v. Shalala*, No. 3:94CV7080 (N.D. Oh. 1995), a decision that has since been reversed. *Id.* at 7a-8a. In *Tulane*, the D.C. Circuit, relying principally on the fact that Congress in enacting the 1986 statute did not affirmatively *prohibit* the Secretary from discarding the existing administrative process for determining the pertinent costs, *see* Pet. App. 46a, found the statute ambiguous, then upheld it under *Chevron* step two. Pet. App. 38a-54a.

On July 26, 1996, the U.S. Court of Appeals for the Eighth Circuit affirmed in a brief *per curiam* opinion. Pet. App. at 1a-3a. The court concluded that the reaudit regulation "must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*." Id. at 3a. The court noted that "it would have been far preferable had

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[4] The PRRB lacks the authority to invalidate a Medicare regulation. It is legally required to comply with all of the Secretary's Medicare regulations. 42 C.F.R. § 405.1867; *Bethesda Hospital Ass'n*, 485 U.S. at 406. Accordingly, the Medicare statute establishes a procedure under which providers may seek judicial review of any question which the PRRB determines it lacks the authority to decide. 42 U.S.C. § 1395oo(f)(1); J.A. 13-14, ¶¶ 21-23, & 23, ¶¶ 21-23.

the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements. . . ." *Id.* However, the court concluded that the statute is "ambiguous" and that the Secretary's regulation represents a reasonable measure to ensure the accuracy of base year amounts. *Id.*

3. The U.S. Court of Appeals for the Sixth Circuit subsequently invalidated the reaudit regulation in *Toledo Hospital v. Shalala*, 104 F.3d 791 (1997), *petition for cert. filed*, No. 96-2046 (June 25, 1997), Pet. App. 20a-37a. The *Toledo* court held that the reaudit regulation conflicts with the plain words of the GME legislation and is also unreasonable because it violates principles of issue preclusion and fundamental fairness.

SUMMARY OF ARGUMENT

1. The statute under review is simple and straightforward. It directs the Secretary to determine an average by dividing one number by another. The numerator is the "amount" of a hospital's GME costs "recognized as reasonable under this subchapter" for 1984. The meaning of those words is clear. When the GME statute was enacted, the Medicare subchapter already included a long-standing process for determining the amount recognized as reasonable for each hospital for each year, including 1984. Thus, as the *Toledo* court properly concluded, it follows that Congress intended that the Secretary would use the amount recognized as reasonable for 1984 in the existing process established under the Medicare subchapter to calculate the average amount recognized as reasonable per resident for the base year.

The GME legislation is carefully crafted. Where Congress intended to delegate authority to the Secretary, it did so expressly, using exact and often significantly circumscribed language. For instance, the statute contains an express delegation to the Secretary to establish rules to

count the number of residents and provides copious guidance. In sharp contrast, the statute delegates no authority to the Secretary with respect to the "amount recognized as reasonable under this subchapter" for 1984 except in unusual circumstances as when a hospital was not in existence in 1984 or did not have a GME program in 1984. The absence of a delegation of authority to the Secretary for this component of the GME payment methodology, after numerous express delegations of carefully defined authority with respect to every other component of the payment methodology, demonstrates that the reaudit regulation departs radically from Congress' intent.

Moreover, the reaudit regulation raises numerous issues that Congress—which is presumed to know the existing regulatory and statutory landscape in areas in which it legislates—undoubtedly would have addressed if it had intended the Secretary's construction. These include the procedures to be used for a special reaudit, the evidentiary problems posed by conducting reaudits after expiration of limitations and record retention periods, and the problems of inconsistencies with PPS caused by the Secretary's revocation of the consistency rule. Congress' failure to address these matters, either in the language of the statute or in the legislative history, furnishes compelling evidence that the reaudit regulation conflicts with congressional intent.

The words used in 42 U.S.C. § 1395ww(h)(2)(A) are not unique. Section 1395ww(h) contains other limits or rates based on amounts "recognized under this subchapter" for a base year. In setting those limits and rates, the Secretary has not conducted a special audit for the base year but has used the base year amount recognized through the normal administrative process established under the Medicare subchapter. In *Georgetown II*, the D.C. Circuit held that costs recognized in administrative decisions directly applicable to the base year must also be recognized for the base year amount used to set future

rates, and the Secretary formally acquiesced in that holding. Thus, the reaudit regulation conflicts with the well-established presumption of consistent construction of language within the same statute.

The reaudit regulation adopts a construction that is inconsistent with the plain words of the statute. It therefore fails *Chevron* step one.

2. The reaudit regulation is patently unreasonable and therefore also flunks *Chevron* step two. It conflicts with the principle of issue preclusion and with principles of fundamental fairness. It subjected hospitals to a *new* audit for 1984 after hospitals had already received notice through the established administrative process that the existing determination was final and binding and they were no longer required to retain audit documentation. Hospitals were suddenly required to reprove claims that they had already proven with finality at a time when they were no longer in a position reasonably to do so.

The original NPR determinations issued in 1986 were the products of extensive on-site audits conducted when documentation was readily available, personnel with knowledge of 1984 events were still at the hospitals, and memories were fresh. If the Secretary wished to re-examine those determinations, she had ample time to do so during the normal three-year reopening period. It is not credible that a 1991 reaudit of 1984, conducted after the expiration of limitations and record retention periods, would produce a more accurate result than the 1986 audit of 1984.

The reaudit regulation also resulted in irrational inconsistencies. It produced determinations of 1984 GME costs for the amount per resident methodology that are different than the determinations of 1984 GME costs actually recognized as reasonable for 1984. In addition, by revoking the consistency rule, the reaudit regulation produced cost classifications in the GME reaudits that are inconsistent with those used to establish PPS rates for

operating costs. As a consequence, the cost reclassifications made by the Secretary in the GME reaudits resulted in clearly allowable costs (whether classified as operating or GME) not being reimbursed under either PPS or the GME amount per resident methodology.

3. The reaudit regulation is also invalid because it is an impermissible retroactive rule. It subjected hospitals to a new audit of 1984 conduct after the limitations period for 1984 had expired. It does not matter that the reaudit of 1984 was to establish rates for fiscal years beginning on or after July 1, 1985, and that the reaudit does not directly affect payment for 1984. The reaudits are reaudits of 1984 conduct, not of 1987 or 1990 or 1993 conduct, and thus 1984 is the proper reference point for determining the retroactivity of the reaudit regulation. Viewed from a 1984 perspective, the reaudit regulation is unquestionably retroactive.

"[E]xtending a statute of limitations after the pre-existing period of limitations has expired impermissibly revives a moribund cause of action. . . ." *Hughes Aircraft Co. v. United States*, 65 U.S.L.W. 4447, 4450 (1997). That principle speaks directly to this case. The reaudit regulation extended (indefinitely) the applicable limitations period for 1984 after the limitations period for 1984 had already expired. It also retroactively revoked a determination that was already final and binding. Under this Court's retroactivity precedents, only an express congressional command could warrant such a result. Because even the Secretary concedes that the statute contains no such express command, the reaudit regulation is clearly invalid on retroactivity grounds.

ARGUMENT

I. THE SECRETARY'S REAUDIT REGULATION VIOLATES THE PLAIN MEANING AND CLEAR INTENT OF 42 U.S.C. § 1395ww(h)(2)(A).

The validity of agency constructions of statutes is generally assessed under the familiar two-step approach established in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).[5] The relevant question under the first step is whether Congress' intent is clear. 467 U.S. at 842-43. If so, Congress' intent must prevail. If not, the relevant question under the second step is whether the agency's construction is reasonable. *Id.* at 843.

In applying *Chevron* step one, the Court does "not start from the premise that [the statutory] language is imprecise." *United States v. LaBonte*, 117 S.Ct. 1673, 1677 (1997). Instead, the Court assumes that "Congress said what it meant" and grants Congress' words their "ordinary meaning." *Id.* "The plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole." *Robinson v. Shell Oil Co.*, 117 S.Ct. 843, 846 (1997). Application of these principles to the question of construction in this case leads to the unmistakable conclusion that Congress intended the Secretary to determine the average base year amount per resident by using as the numerator the base year amount recognized as reasonable through the existing process established under the Medicare subchapter many years earlier.

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[5] For the reasons discussed in § III below, petitioner contends that the "clear statement" standard in *Landgraf v. USI Film Products*, 114 S.Ct. 1483 (1994), not the *Chevron* standard, applies in this case. However, in §§ I-II, petitioner will assume, for purposes of argument, that the *Chevron* standard applies.

A. The Reaudit Regulation Conflicts With the Ordinary Meaning of the Words in 42 U.S.C. § 1395ww(h)(2)(A).

The GME statute prescribes several steps for computing a hospital's payment rate under the GME amount per resident methodology. This case involves the first step. The relevant paragraph provides:

> The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A).

This is not a complex provision. The statute directs the Secretary to calculate an "average." As all agree, she does this by dividing (A) the "amount recognized as reasonable under this subchapter" for a hospital's 1984 cost reporting year by (B) the hospital's number of FTE residents for that period. The words "amount recognized as reasonable under this subchapter" have a plain and fixed meaning, and, when read in context, quite clearly direct the Secretary to calculate the average using as the numerator the amount established under the existing administrative process for recognizing such amounts. The Secretary's reaudit regulation discards that process and thus conflicts with the plain intent of Congress.

Contrary to the Secretary's self-serving construction, the meaning of the words "amount recognized as reasonable under this subchapter" is clear. The referenced "subchapter" is subchapter XVIII of the Social Security Act, which "subchapter" is often referred to as the Medicare statute. Subchapter XVIII contains a long-established process for determining the amount of Medicare payment

recognized as reasonable for *each* hospital for *each* year. *See Bethesda Hospital Ass'n*, 485 U.S. at 400-01; *Hospital Ass'n of Rhode Island v. Secretary of HHS*, 820 F.2d 533, 534 (1st Cir. 1987); *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615, 617 (D.C. Cir. 1994). It directs the Medicare intermediary to make a "final determination" (the NPR) as to each hospital's payment entitlement for each cost reporting year. 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. §§ 405.1801 (a)(1), 405.1803(a)(1), (b) (1985). A hospital dissatisfied with this determination has 180 days to appeal to the PRRB. 42 U.S.C. § 1395oo(a)(3); 42 C.F.R. §§ 405.1803(b), 405.1835(a) (1985). The intermediary may reopen a final determination of a provider's reasonable costs, "with respect to findings on matters at issue in such determination," within a three-year period. 42 C.F.R. § 405.1885(a) (1985). Once that period expires, the determination is "final and binding," unless timely appealed. 42 C.F.R. § 405.1807 (1985).

As part of the base year audit, the Secretary determined the amount of GME costs "recognized as reasonable" under this regulatory process. However, she did not, in the base year audit, determine the number of residents for GME purposes, and thus she obviously did not determine the *average* amount "recognized as reasonable" *per resident*. Thus, to implement the new payment methodology, the Secretary needed to determine the number of residents (a matter addressed by 42 U.S.C. § 1395ww (h)(4)) and do a mathematical calculation not done for the base year audit, *i.e.*, divide the GME costs "recognized as reasonable" in the base year audit by the number of residents to produce the *average* base year amount per resident. But the determination of this average in no way required, or allowed, the Secretary to "redetermine" the numerator. As the *Toledo* court correctly concluded, 42 U.S.C. § 1395ww(h)(2)(A) is "not at all complex" and

"merely directs the Secretary to divide one number by another." [6] *Toledo*, Pet. App. 31a.

Congress is presumed to know the law in the areas in which it legislates. *See Bowen v. Massachusetts*, 487 U.S. 879, 896 (1988) ("the well-settled presumption [is] that Congress understands the state of existing law when it legislates"); *Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-185 (1988) ("We generally presume that Congress is knowledgeable about existing law pertinent to the legislation it enacts."); *ICC v. Texas*, 479 U.S. 450, 458 (1987) ("Presumably, in enacting § 10505, Congress was aware of the Commission's consistent practice of regulating railroads as 'rail carriers' even when they performed Plan II intermodal service."). *Accord Director, OWCP v. Perini North River Assocs.*, 459 U.S. 297, 319-320 (1983). The Sixth Circuit was therefore clearly correct in concluding:

> When Congress passed the GME amendment in 1986, it knew that there was an administrative scheme in place that would determine the reasonable GME costs for providers for fiscal 1984. . . . It follows that Congress must have contemplated that the Secretary would use those administratively determined reasonable costs as the basis for calculating the average GME cost per full-time-equivalent resident.

Toledo, Pet. App. 30a-31a. Thus, the words "amount recognized as reasonable under this subchapter" can mean

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[6] The *Tulane* court suggested that "determine" is an "activist" word that is reasonably construed as authorizing the Secretary to conduct a special reaudit of 1984 GME costs. 987 F.2d at 796 n.6. But for purposes of establishing an "average," "determine" is no more "activist" than "compute" or "calculate." *Directing the Secretary to "determine" an "average" by dividing (A) by (B) does not authorize the Secretary to "redetermine" (A).* "Determine" is an "activist" word only under an "activist" construction that departs from the word's ordinary meaning when used in the context of determining an average.

only one thing, *i.e.*, the amount established through the normal administrative process, which, in the absence of an appeal or a timely reopening, is the amount established in the NPR.

That conclusion not only comports with the natural meaning of the words used but is eminently reasonable. When the GME legislation was enacted, there were no "final and binding" determinations of the amount recognized as reasonable for 1984. The intermediaries were either in the process of auditing the base year or had just recently issued NPRs. Even where NPRs had been issued, the base year remained subject to reopening for almost three years. Thus, as the Sixth Circuit concluded, the natural construction of the statute is consistent with the aim of ensuring that the 1984 costs were accurate. *Toledo*, Pet. App. 31a-32a. To compute the average, all the Secretary was required to do with respect to 1984 costs was use the "amount recognized as reasonable" in the process long established under the Medicare subchapter. *Id.*

Tellingly, to effectuate her construction, the Secretary effectively had to revoke her own limitations and document retention periods after they had expired. Consequently, hospitals were suddenly—and quite unexpectedly—placed in the position of having to reprove claims they had already proven with finality at a time when many hospitals no longer possessed, and were not required to possess, the necessary documentation. The plain meaning of the 1986 statute, especially when read in context, does not allow the Secretary to repudiate the existing process for recognizing 1984 costs and invent a new one.

"[W]here a common-law principle is well established, as are the rules of preclusion . . ., the courts may take it as given that Congress has legislated with an expectation that the principle will apply except 'when a statutory purpose to the contrary is evident.'" *Astoria Federal Savings and Loan Ass'n v. Solimino*, 501 U.S. 104, 108

(1991). The reaudit regulation defeats that expectation. *Toledo*, Pet. App. 33a.

B. Reading 42 U.S.C. § 1395ww(h)(2)(A) in the Context of the GME Legislation as a Whole and of Other Provisions in the Medicare Statute Mandates a "Plain Meaning" Construction.

1. The absence of a delegation of authority with respect to the words "amount recognized as reasonable under this subchapter" in 42 U.S.C. § 1395ww(h)(2)(A) contrasts with the explicit authority conferred on the Secretary in numerous other sections of the GME legislation.

The provision at issue in this case is only one of many provisions in the GME legislation (42 U.S.C. § 1395ww (h)). The legislation is carefully crafted. At numerous points, Congress recognized the necessity of delegating authority to the Secretary and did so explicitly. At other points, Congress defined its intent with specificity and withheld a delegation of authority to the Secretary.

A prime example of a delegation of authority to the Secretary is found in 42 U.S.C. § 1395ww(h)(4) regarding the resident count (*i.e.*, the denominator in the base year amount per resident formula and the multiplier in years subject to payment under the GME statute). A resident count had no bearing on Medicare reimbursement for GME under the "reasonable cost" payment system in effect in 1984, and thus the Secretary had never established a methodology, under "reasonable cost" principles, to determine the number of residents. Accordingly, Congress expressly authorized the Secretary to establish rules "for the computation of the number of full-time-equivalent residents in an approved medical residency training program" and furnished over 400 words of detailed guidance. 42 U.S.C. § 1395ww(h)(4). The legislation contains at least ten other express delegations of

authority to the Secretary, always defined with exactitude and often significant circumscription.[7]

Under the GME legislation, several elements establish the amount of a hospital's GME payment for a particular

[7] (1) § 1395ww(h)(1) requires the Secretary to "provide for an allocation" of GME payments between the two parts of Medicare (A and B) and furnishes guidance for doing so; (2) with respect to the inflation factor to be used for future years, § 1395ww(h)(2)(D) directs the Secretary to make "appropriate adjustments to reflect previous under- or over-estimations . . . in the projected percentage change in the consumer price index"; (3) for a hospital not in existence in 1984 or without an approved GME program in that year, § 1395ww(h)(2)(E) directs the Secretary, in the first year the hospital begins an approved residency training program, to "provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs"; (4) § 1395ww(h)(3)(C) bases the "medicare patient load" on a fraction, the denominator of which is "the total number of inpatient-bed-days (as established by the Secretary)"; (5) § 1395ww(h)(5)(A) defines "approved medical residency training program" to include "formal postgraduate training programs in geriatric medicine approved by the Secretary"; (6) § 1395ww(h)(5)(D)(iii) defines a "foreign medical graduate" to exclude a graduate of "a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose"; (7) § 1395ww(h)(5)(F)(ii) defines the term "initial residency period" to provide special treatment for a resident "in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish"; (8) § 1395ww(h)(5)(G)(iii)(I) delegates to the Secretary the authority, under carefully defined circumstances, to "increase the period of board eligibility" for a residency specialty program; (9) § 1395ww(h)(5)(G)(iii)(II) delegates to the Secretary the authority, again under carefully defined circumstances, to "decrease the period of board eligibility" for a residency specialty program; and (10) for a hospital that received government funds (other than Medicare or Medicaid) for the operation of a residency program in 1984, § 1395ww(h)(5)(J)(i)(I) requires the Secretary to "provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this subchapter if the hospital had not received such funds."

year: (A) the hospital's 1984 GME costs are divided by (B) the number of the hospital's 1984 FTE residents to produce an average base year amount per resident; that average is multiplied by (C) an inflation factor; the adjusted base year average is multiplied by (D) the hospital's number of FTE residents in the payment year; and finally (E) an apportionment is made between Medicare part A and Medicare part B. The statute delegates clearly defined authority to the Secretary for elements (B)-(E). Indeed, it even delegates authority to the Secretary with respect to element (A), 1984 GME costs, in unusual circumstances—where a hospital was not in existence in 1984 or did not have a GME program in 1984 (42 U.S.C. § 1395ww(h)(2)(E)) and where a hospital was receiving payment for GME in 1984 from a government program other than Medicare or Medicaid (42 U.S.C. § 1395ww(h)(5)(J)(i)(I)). Except in those instances, however, the statute delegates no authority to the Secretary with respect to 1984 GME costs recognized as reasonable under the Medicare subchapter.

The numerous specific delegations of meticulously-defined authority in the GME legislation show that when Congress intended to delegate authority to the Secretary, it did so expressly and deliberately. Yet the GME statute contains not a single word conferring any authority on the Secretary to conduct a special audit for, or make a new determination of, or in any way amend, the GME costs recognized as reasonable under the Medicare subchapter for 1984. Thus, the *Tulane* district court was clearly correct in finding that the "conclusion that Congress did not intend to authorize a reaudit follows naturally when looked at within the framework of the provision as a whole." *Methodist Hospitals of Memphis v. Sullivan*, 799 F. Supp. 1210, 1218 (D.D.C. 1992), *rev'd*, *Tulane*. Numerous precedents of this Court support the district court's logic. *See, e.g., City of Chicago v. Environmental Defense Fund*, 114 S. Ct. 1588, 1593 (1994) ("'[I]t is generally presumed

that Congress acts intentionally and purposely' when it 'includes particular language in one section of a statute but omits it in another' "); *INS v. Cardoza Fonseca*, 480 U.S. 421, 432 (1987) (" '[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.' "). Here, the omission of a delegation of authority in 42 U.S.C. § 1395ww(h)(2)(A) contrasts with the inclusion of a delegation in not just "one section of the statute" but in at least eleven sections of the statute.[8]

The Medicare statute and regulations long ago established the process by which the Secretary determines the amount of GME costs recognized as reasonable for each cost reporting year. If Congress had intended, when it enacted the GME legislation, for the Secretary to bypass that process and create a new process, it surely would have said so. *See Director, Office of Workers' Compensation Programs v. Newport News Shipbuilding and Dry Dock Co.*, 115 S. Ct. 1278, 1288 (1995) ("The withholding of agency authority is as significant as the granting of it, and we have no right to play favorites between the two"). Congress did not do so.

[8] The Secretary seems to be searching for a statutory basis for her purported authority to issue the reaudit regulation. In the *Federal Register* preamble, she expressly disavowed reliance on her general rulemaking authority to issue the reaudit regulation. Specifically, the Secretary stated: "Here the agency is not relying on our general grant of rulemaking authority to support retroactive application, but, rather, on a specific congressional enactment [the GME statute]." 54 Fed. Reg. 40,314 (1989). In court, however, the Secretary invoked instead her general rulemaking authority in 42 U.S.C. § 1395hh(a). *See* Brief of Defendant Appellee at 18-19. An agency's general rulemaking powers, of course, do not confer on the agency the authority to override Congress' clear intent. *Board of Governors of Fed. Res. Sys. v. Dimensions Financial Corp.*, 474 U.S. 361, 374 (1986). Moreover, 42 U.S.C. § 1395hh does not confer retroactive rulemaking authority on the Secretary. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213-214 & n.3 (1988).

2. Had Congress intended the Secretary's construction, it would have worded the statute differently and addressed numerous problems created by that construction.

The only words in the GME statute relating to the numerator of the base year amount per resident determination are "amount recognized as reasonable under this subchapter for direct graduate medical education costs" "for the hospital's cost reporting period that began during fiscal year 1984." 42 U.S.C. § 1395ww(h)(2)(A). In terms, these words do not delegate authority to the Secretary. Nonetheless, based on these words, the Secretary has taken extraordinary actions that significantly affect not only GME payments but also payments for operating costs under PPS.

The Secretary effectively revoked the reopening and record retention standards applicable to 1984 after those standards had already expired. She directed the Medicare intermediaries to conduct a reaudit that has produced an amount for the numerator used to determine the base year average that in many instances differs significantly from the amount actually recognized as reasonable for 1984. 42 C.F.R. § 413.86(e)(1)(iii). She furnished instructions to the intermediaries regarding substitution of data from other years where data is no longer available for 1984. 55 Fed. Reg. 36,063-64 (1990). She revoked the consistency rule in effect in 1984 for purposes of the GME reaudit of 1984. 42 C.F.R. §§ 412.113(b)(3), 413.86(e)(1)(ii)(B)-(C); 54 Fed. Reg. 40,315-17, J.A. 26, 29-30. She significantly modified the principles in her PPS regulations regarding the finality of the PPS hospital-specific rate. 42 C.F.R. § 405.477(c)(2) (1983); 42 C.F.R. § 413.86(j); 54 Fed. Reg. 40,318-19, J.A. 36-38. She retroactively authorized, under certain circumstances, adjustments to the PPS hospital-specific rate for PPS transition years, even though all those years had been completed when she issued the reaudit regulations, but she declined

to authorize corresponding adjustments to the PPS federal rate. 54 Fed. Reg. 40,301 (1989).

In applying the first step of *Chevron*, courts may not assume that the statutory language is "imprecise" but must assume instead that "Congress said what it meant." *United States v. LaBonte*, 117 S. Ct. at 1677. The GME statute says nothing about a special reaudit or changing reimbursement standards or revoking limitation periods or amending payments under PPS. It simply directs the Secretary to determine an average, the numerator of which would be established under the existing administrative process in the Medicare statute. Both the *Toledo* court and the *Tulane* district court correctly noted that had Congress intended the Secretary's construction, it would have worded the statute quite differently. *Toledo*, Pet. App. 33a-34a; *Methodist Hospitals of Memphis v. Sullivan*, 799 F. Supp. at 1218. To accept the Secretary's construction, the Court would have to assume that Congress spoke with incredible imprecision and said the exact opposite of what it meant.

In *EEOC v. Arabian American Oil Co.*, 499 U.S. 244, 255-56 (1991), this Court rejected the EEOC's view that Title VII of the Civil Rights Act applies overseas because, among other things, Congress did not address in the Act issues (*e.g.*, overseas enforcement mechanisms and conflicts with foreign laws and procedures) that it almost certainly would have addressed if it had intended the agency's construction. That same logic requires rejection of the Secretary's construction here.

If Congress had intended for the Secretary to conduct a special reaudit of 1984 costs after expiration of the reopening period established under the Medicare subchapter, it undoubtedly would have addressed many issues, including the following:

(1) the period during which the special reaudit was to be conducted;

(2) the procedures to be used for the reaudit;

(3) the evidentiary problems created by conducting a special reaudit after expiration of reopening and document retention periods;

(4) whether data from a year other than 1984 could be used for the 1984 reaudit and, if so, under what circumstances;

(5) whether the Secretary could depart from the reimbursement principles in effect in 1984 and, if so, to what extent;

(6) whether the Secretary could make reclassifications of costs in the reaudit inconsistent with the classifications used for the PPS hospital-specific rates and federal rates; and

(7) if the Secretary were allowed to depart from the PPS classifications for purposes of the GME reaudit, whether she had to make conforming reclassifications under PPS and, if so, to what extent and how.

Although the GME legislation reflects a close attention to detail, it is silent with respect to all of the issues addressed in the preceding paragraph. That is not surprising under a plain meaning construction of § 1395ww (h)(2)(A) because a plain meaning construction avoids all those issues. However, the Secretary's construction requires that all the identified issues be addressed. The fact that Congress did not do so—indeed, the fact that Congress was completely silent on all these weighty matters—furnishes persuasive evidence that the agency's construction departs radically from Congress' intent.[9]

[9] The legislative history is also silent on these matters. The fact that the legislative history does not address any of the matters or furnish any support for the extraordinary actions taken by the Secretary in the reaudit regulations further demonstrates the error of the Secretary's construction. *See Connecticut National Bank v. Germain*, 503 U.S. 249, 255 (1992) (Stevens, J., concurring) ("If Congress had intended such a significant change . . ., some indica-

3. *The Secretary's construction of the words "amount recognized as reasonable under this subchapter" in 42 U.S.C. § 1395ww(h)(2)(A) conflicts with her construction, and the courts' construction, of nearly identical language in other sections of the Medicare subchapter.*

As addressed above, an analysis of 42 U.S.C. § 1395ww (h)(2)(A) in the context of other provisions in § 1395ww(h) plainly supports petitioner's "plain meaning" construction and rebuts the Secretary's "activist" construction. A review of the statutory provision in the broader context of other subsections of 42 U.S.C. § 1395ww does so as well.

The basic concept in § 1395ww(h)(2)(A) of using an amount recognized as reasonable in a base year for future payment purposes parallels other provisions of § 1395ww enacted just a few years earlier. In the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Congress enacted two such limits applicable to cost reimbursement.[10] Pub. L. No. 97-248, § 101(a)(1). In neither case did the Secretary conduct a special reaudit of the designated base year to determine the amount of the limit. In both cases, the Secretary used the final determination of allowable costs established under the normal audit and review process for the base year itself in determining the amount of the limit.[11]

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tion of this purpose would almost certainly have found its way into the legislative history").

[10] For one of these, Congress specified that the limit "shall in no event be lower than the allowable operating costs of inpatient hospital services . . . *recognized under this subchapter* for such hospital's [base year]." 42 U.S.C. § 1395ww(a)(1)(C) (emphasis added). The other limit (denoted the "target amount") was defined in terms of "the allowable operating costs of inpatient hospital services . . . *recognized under this subchapter* for such hospital for [the base year]." 42 U.S.C. § 1395ww(b)(3)(A)(i) (emphasis added).

[11] Although the TEFRA provisions were more complex than the GME legislation, the Secretary issued extensive implementing regulations on September 30, 1982, less than one month after the President signed the TEFRA legislation. *See* 47 Fed. Reg. 43,281-43,338 (1982).

In 1983, Congress incorporated the "target amount" into PPS, again using a hospital's allowable operating costs "recognized under this subchapter" for a base year to determine future reimbursement (the PPS "hospital-specific rate"). Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e); 42 U.S.C. §§ 1395ww (d)(1)(A)(i)(I), (ii)(I) (incorporating 42 U.S.C. § 1395ww(b)(3)(A)). The Secretary did not reaudit the base year costs to be used for future years,[12] but she issued a regulation that permitted the use of two different base year amounts in limited circumstances.[13] That regulation was invalidated in *Georgetown II*, which required uniformity in the base year amounts. The court concluded that costs that were "recognized under this subchapter" in a final administrative decision for the base year had to be recognized in the base year amount used for the PPS hospital-specific rate. 862 F.2d at 327. The Secretary subsequently issued a nationwide ruling acquiescing in the court decision. *See* Health Care Financing Administration Ruling 89-1, [1989 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 37,614 (1989), District Court Docket Item 14 (Exhibit 1).

In other provisions of § 1395ww, statutory references to amounts "recognized under this subchapter" for base years have been construed by the Secretary and the courts to mean the amounts actually recognized in the final

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[12] Although PPS was far more complex than the GME legislation, the Secretary issued implementing regulations on September 1, 1983, a little more than four months after the President signed the PPS legislation. *See* 48 Fed. Reg. 39,752-39,890 (1983).

[13] The Secretary used the base year (1982) NPR to establish the PPS hospital-specific rate, but in most instances she declined to adjust the hospital-specific rate to reflect subsequent adjustments to the 1982 NPR resulting from reopenings, administrative decisions, and judicial decisions.

determinations established through the normal audit and review process for the base years themselves.[14] Only in this instance has the Secretary sought to conduct an extraordinary reaudit to establish a new base year amount to be used to set rates for subsequent years.[15] Thus, the Secretary's regulation conflicts with the " 'normal rule of statutory construction' that 'identical words used in different parts of the same act are intended to have the same meaning.' " *Sullivan v. Stroop*, 496 U.S. 478, 484 (1990), *quoting Sorenson v. Secretary of Treasury*, 475 U.S. 851, 860 (1986); *see also Patterson v. Shumate*, 504 U.S. 753, 766 (1992) (Scalia, J., concurring) ("consistency of usage within the same statute is to be presumed").

C. The Absence of an Express Prohibition Barring a Special Reaudit of GME Costs After Expiration of Applicable Limitation and Document Retention Periods Does Not Create Ambiguity.

It is of course true that Congress did not *expressly* prohibit the Secretary from reauditing 1984 GME costs

[14] The TEFRA and PPS limits and rates also required the Secretary to determine an "average." The average was computed on a "per [patient] admission or per [patient] discharge basis." 42 U.S.C. § 1395ww(a)(4).

In the preamble to the reaudit regulations, the Secretary noted that, in enacting the GME legislation, "Congress provided . . . for a hospital-specific payment [for GME] that may be characterized as similar to the hospital-specific rate used in the prospective payment system." 54 Fed. Reg. 40,309 (1989). The *Tulane* district court concluded that "the principles of interpretation" for the two provisions (42 U.S.C. §§ 1395ww(b)(3)(A) and 1395ww(h)(2)(A)) are "the same." *Methodist Hospitals of Memphis v. Sullivan*, 799 F.Supp. at 1217.

[15] The 1984 base year selected for the GME amount per resident methodology is the same base year that the Secretary had previously selected for her freeze on increases in medical education costs. 42 C.F.R. § 405.421(a)(2)(i) (1985); 50 Fed. Reg. 27,732 (1985). The Secretary made clear when she adopted the freeze that the final GME cost determination for 1984 would also be used for purposes of the freeze. 50 Reg. 27,722, 27,726 (1985).

after expiration of the 1984 reopening and record retention periods and from using the reaudited amount for the GME amount per resident methodology. But, then, Congress could hardly be expected to expressly prohibit conduct that it could not possibly have anticipated and that conflicts with its express command. Thus, the Sixth Circuit in *Toledo* was correct in concluding that a court may not "presume a delegation of interstitial rulemaking authority when the claimed ambiguity in the statute stems not from the use of a word with several plausible interpretations, nor from the statute's lack of specificity regarding mundane procedural issues, but from nothing more than the failure of Congress to proscribe explicitly an unusual procedure which may be plainly at odds with the result Congress was trying to reach." Pet. App. 29a.

In *Tulane*, the D.C. Circuit did just that, finding ambiguity in the fact that Congress did not expressly prohibit her from abandoning the established administrative process and reopening final and binding determinations made under that process. *See* Pet. App. 46a. Since *Tulane*, however, the D.C. Circuit has followed an approach under *Chevron* step one that is entirely consistent with the one taken by the Sixth Circuit in *Toledo* and faithful to this Court's precedents. Thus, in rejecting a construction of the National Mediation Board, the D.C. Circuit, in an *en banc* decision authored by now Chief Judge Edwards, said:

> To suggest, as the Board effectively does, that *Chevron* step two is implicated any time a statute does not expressly *negate* the existence of a claimed administrative power (*i.e.* when the statute is not written in "thou shalt not" terms), is both flatly unfaithful to the principles of administrative law outlined above, and refuted by precedent. . . . Were courts to *presume* a delegation of power absent an express *withholding* of such power, agencies would enjoy virtually limitless hegemony, a result plainly out of keeping with *Chevron* and quite likely with the Constitution as well.

Railway Labor Executives' Ass'n v. National Mediation Board, 29 F.3d 655, 671 (D.C. Cir. 1994) (*en banc*), *cert. denied*, 115 S. Ct. 1392 (1995) (original emphasis); *see also Backcountry Against Dumps v. EPA*, 100 F.3d 147, 151 (D.C. Cir. 1996); *American Petroleum Inst. v. U.S. EPA*, 52 F.3d 1113, 1120 (D.C. Cir. 1995); *Ethyl Corp. v. EPA*, 51 F.3d 1053, 1060 (D.C. Cir. 1995). That approach faithfully follows the course set by this Court. *See, e.g., Adams Fruit Co., Inc. v. Barrett*, 494 U.S. 638, 650 (1990) ("[I]t is fundamental 'that an agency may not bootstrap itself into an area in which it has no jurisdiction.' "); *Board of Governors of Fed. Res. Sys. v. Dimension Financial Corp.*, 474 U.S. at 374 ("The statute may be imperfect, but the board has no power to correct flaws that it perceives in the statute it is empowered to administer").

* * * *

The Secretary's reaudit regulation conflicts with the plain meaning of 42 U.S.C. § 1395ww(h)(2)(A). "When the words of a statute are unambiguous, then . . . 'judicial inquiry is complete.' " *Connecticut National Bank v. Germain*, 503 U.S. at 254. Thus, in this case, the first step of *Chevron* is also the last.[16]

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[16] In her brief responding to petitioner's petition for certiorari (at 10-11), the Secretary erroneously suggests, for the first time in this case, that a provision in the Omnibus Budget Reconciliation Act of 1990 ("OBRA 1990"), Pub. L. No. 101-508, reflects Congress' approval of the Secretary's reaudit regulations. The 1990 statute, which makes no reference to the Secretary's regulations, provides that the Secretary "may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under [42 U.S.C. § 1395ww(h)]." OBRA 1990, § 4004(a)(1). It also provides that recoupments be gradually phased in over a four-year period. *Id.* § 4004(a)(2).

The 1990 legislation was enacted because by 1990 the Secretary had failed to apply § 1395ww(h) to *any* hospital for *any* cost reporting year. Instead, even though "reasonable cost" principles were inapplicable to fiscal years beginning on or after July 1, 1985, the Secretary had continued, from 1986 onward, to settle those years under "reasonable cost" principles. Thus, recoupment was required for those years to effectuate § 1395ww(h), irrespective of the question at issue in this case. The 1990 legislation ensured that the recoupment would occur gradually over a substantial period of time, thus avoiding the severe cash flow problems that recoupment might otherwise cause.

The 1990 legislation expresses no opinion regarding the merits of the Secretary's base year amount per resident determinations. Indeed, it could not possibly have done so because, at the time, the Secretary had not yet made the determinations. The nonjudgmental nature of Congress' action is evident from its reference to the recoupment of *"alleged* overpayments." OBRA 1990, § 4004(a)(1) (emphasis added). Thus, the Secretary's belated reliance on the 1990 legislation is misplaced.

II. EVEN ASSUMING ARGUENDO AN AMBIGUITY IN THE STATUTORY LANGUAGE, THE REAUDIT REGULATION ADOPTS A PATENTLY UNREASONABLE CONSTRUCTION.

An agency construction of an ambiguous statutory provision is not necessarily valid under *Chevron*. To be valid under *Chevron* step two, the agency's construction must be "reasonable." 467 U.S. at 844.

The reaudit regulation is patently unreasonable in numerous respects. It conflicts with the principle of issue preclusion and with principles of fundamental fairness. It is based on absurd assumptions. It creates irrational inconsistencies with the GME base year determination and with the cost classifications underpinning the entire PPS payment methodology. Thus, even if the reaudit regulation could pass *Chevron* step one, it would still fail *Chevron* step two.

A. The Reaudit Regulation Conflicts With the Principle of Issue Preclusion and With Principles of Fundamental Fairness.

The reaudit regulation set aside, in many cases, determinations that were already "final and binding." 42

C.F.R. § 405.1807. Those determinations were made shortly after the close of the 1984 year. The hospitals had proven their claims in formal on-site audits at a time when there were few evidentiary problems—documentation was still readily available, personnel had personal knowledge of 1984 events, and memories were still sharp.

The reaudit regulation set aside these "final and binding" determinations at a time when hospitals could no longer reasonably be expected to reprove their claims. Hospitals had previously received notice through the Secretary's regulations that 1984 physician allocation agreements and time studies could be discarded. 42 C.F.R. § 405.481(g)(3) (1985). Hospitals had also previously received notice through the Secretary's regulations that "findings on matters at issue" in the determination for 1984 were final and no longer subject to reopening. 42 C.F.R. § 405.1885(a) (1985). In many cases, key personnel had left, with positions often having turned over several times since 1984. If still at the hospital, their recollection of events in 1984 was generally dim, at best. Nonetheless, the reaudit regulation imposed on hospitals the obligation to reprove claims that they had already proven with finality several years earlier.

The reaudit regulation, therefore, conflicts with the principle of issue preclusion. A formal determination had already been made with respect to the amount recognized as reasonable under the Medicare statute for 1984 and that determination and "findings on matters at issue" therein were no longer subject to reopening. 42 C.F.R. § 405.1885(a). Res judicata and collateral estoppel apply to final administrative determinations so long as there was an adequate opportunity to contest the issue in the original determination, as there clearly was here. *United States v. Utah Construction & Mining Co.*, 384 U.S. 394, 422 (1966); *Draper v. Sullivan*, 899 F.2d 1127, 1130-31 (11th Cir. 1990). It is irrational to assume that Congress intended the Secretary to retroactively revoke her own reopening standards. As the *Toledo* court concluded, "the principle of issue preclusion prevents the Secretary from requiring providers to re-establish the costs that they already proved years ago." Pet. App. 36a.

Parties are of course entitled to question and contest the validity of a determination so long as it is subject to further review or reopening. Once final, however, a determination is presumed correct. *See Medical Arts Building Ltd. v. Eralp*, 290 N.W.2d 241, 246 (N.D. 1980) ("The words 'final' and 'conclusive' . . . mean that the matter decided is irrefutable and admits of no explanation of contradiction"). *Finality brings repose.* Indeed, the very notion of "redetermining" a determination that is "final and binding" is an oxymoron.

The Medicare three-year reopening period is the functional equivalent of a statute of limitations. *See Pellham Bay General Hospital v. Schweiker*, [1984-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 33,468 at 9360 & n.9 (D.D.C. 1983). Statutes of limitations:

> are not simply technicalities. . . . [T]here comes a point at which the delay of a plaintiff in asserting a claim is sufficiently likely either to impair the accuracy of the fact-finding process or to upset settled expectations that a substantive claim will be barred without respect to whether it is meritorious.

Board of Regents of the University of the State of New York v. Tomanio, 446 U.S. 478, 487 (1980). Statutes of limitations:

> represent a pervasive legislative judgment that it is unjust to fail to put the adversary on notice to defend within a specified period of time and that "the right to be free of stale claims in time comes to prevail over the right to prosecute them." . . . These enactments are statutes of repose; . . . they protect defendants and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death

> or disappearance of witnesses, fading memories, disappearance of documents, or otherwise.

United States v. Kubrick, 444 U.S. 111, 117 (1979) (citations omitted).

The Medicare reopening standards were intended to ensure, not impede, accuracy. The reaudit regulation allows exactly what the reopening standards were designed to prevent—the impairment of the "accuracy of the fact-finding process" and the "unjust" treatment of hospitals that had already been put on notice that the determination of 1984 costs was final and binding. It is not credible that a 1991 audit of 1984, conducted two years after that year was closed under long-established Medicare principles, would yield more accurate results than did the 1986 audit of 1984.

It is well-established that "[j]ust determinations of fact cannot be made when, because of the passage of time, the memories of witnesses have faded or evidence is lost." *Wilson v. Garcia*, 471 U.S. 261, 271 (1985). It is equally well-established that a "fundamental requirement of due process is 'the opportunity to be heard' . . . at a meaningful time and in a meaningful manner," *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965), which obviously would not be the case if the action is not even initiated until after the expiration of the limitations period. Indeed, as this Court has recently recog ized, "extending a statute of limitations after the pre-existing period of limitations has expired impermissibly revives a moribund cause of action." *Hughes Aircraft Co. v. United States*, 65 U.S.L.W. at 4450. Moreover, construing a statute to lengthen a limitations period "conflicts with a basic objective—repose—that underlies limitations periods." *Klehr v. A.O. Smith Corp.*, 65 U.S.L.W. 4514, 4517 (1997). The reaudit regulation runs afoul of these bedrock principles. Thus, the Sixth Circuit was correct in finding that the Secretary "ignored . . . the basic fairness issues implicated." *Toledo*, Pet. App. 37a.

Significantly, in stark contrast with her position in this case, the Secretary has strongly defended the strict application of Medicare finality principles in the past, contending that finality outweighs interests in accuracy. For instance, when the Secretary acknowledged in 1986 that her 1979 regulation governing the apportionment of malpractice insurance costs was invalid, she relied on the principle of administrative finality to justify not making corrections to closed years, including PPS base years, stating:

> [T]he general importance of ensuring the finality of decisions on reimbursement issues outweighs whatever benefits might be received by providers whose malpractice insurance costs are outside the reopening period. Our rules of administrative finality and reopening protect both the Medicare Trust Funds and the provider community from unexpected contingencies that might arise long after a decision becomes final. . . . *Regardless of whether our finality and reopening rules benefit or disadvantage providers in a specific case, their overall role of providing certainty in the administrative process is important enough to warrant their consistent application.*

51 Fed. Reg. 11,187 (1986) (emphasis added). The reaudit regulation is hardly in keeping with the Secretary's stated commitment to "consistent application" of the Medicare "finality and reopening" standards.

Ironically, when a reopening would work to her disadvantage, the Secretary often refuses to reopen even during the three-year reopening period. For instance, after the Secretary's construction of the statute governing the Medicare adjustment for hospitals that serve a disproportionate share of low-income patients was struck down by all four courts of appeals to address the matter, the Secretary recently issued a ruling acquiescing in the construction mandated by the court decisions. Health Care Financing Administration Ruling 97-2, [1997 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 45,105 (1997). However, the ruling expressly states that "[w]e

will not reopen settled cost reports based on this issue," even though those reports had been settled under a clearly invalid policy. *Id.* at 53,000.

Similarly, after this Court invalidated the Medicare retroactive wage index rule in *Bowen v. Georgetown Univ. Hosp.*, the Secretary issued a ruling conceding defeat with respect to the retroactive wage index rule, the related retroactive malpractice rule, and, as noted above, the PPS issue in *Georgetown II*. Health Care Financing Administration Ruling 89-1, [1989 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 37,614 (1989), District Court Docket Item 14 (Exhibit 1). However, the ruling did not provide for any reopenings and allowed the intermediaries to apply the Secretary's concessions only to "pending" appeals. *Id.*; *Tucson Medical Center v. Sullivan*, 947 F.2d 971, 978, 982 (D.C. Cir. 1991). There is a fundamental inconsistency in the Secretary's refusal to reopen cost reports still within the three-year reopening period to correct underpayments resulting from the application of a policy unanimously struck down by this Court, but insisting on reopening cost reports after expiration of the three-year reopening period to conduct a reaudit of GME costs for 1984.

B. The Reaudit Regulation Is Based on Flawed and Unreasonable Assumptions.

The reaudit regulation is also unreasonable because it is based on several irrational assumptions.

First, the Secretary apparently assumed that she was free to defer implementation of the GME payment methodology as long as she liked. Even though the GME legislation made "reasonable cost" payment principles inapplicable to GME for cost reporting years beginning on or after July 1, 1985, the Secretary continued, for the five year period 1986-1991, to settle GME costs under "reasonable cost" principles because she had not determined the base year amounts per resident necessary to effectuate

the GME statute. It was not until 1991 that she began applying the GME payment methodology to recoup payments made under the "reasonable cost" payment methodology.

Congress made the GME payment methodology effective for cost reporting years beginning on or after July 1, 1985. Pub. L. No. 99-272, § 9202(b). Absolutely nothing in the legislation suggests that Congress intended that implementation of the statute be deferred or that the Secretary continue to use "reasonable cost" principles for years beginning on or after July 1, 1985. Since Congress clearly intended immediate implementation, it follows that Congress intended the Secretary to use the base year audit determination for 1984 to establish the base year amount for the amount per resident methodology.

Second, the Secretary erred in her belief that a reaudit was necessary for 1984. The original determinations were *audited* figures. The original audits were performed shortly after the close of the 1984 year, when audit documentation was still readily available, when memories were still fresh, and when hospital and intermediary personnel had not substantially turned over. The passage of time did not improve the reliability of evidence. A 1991 reaudit posed enormous evidentiary and due proces problems that did not exist for the 1986 audit.[17]

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[17] By 1984, the Medicare intermediaries had been conducting audits under "reasonable cost" principles for nearly twenty years. Thus, they were experienced in auditing GME costs. Moreover, the Medicare intermediaries were able to devote their full attention to GME costs for the year serving as the GME base year. Since that year was also the first year under the new PPS for operating costs, the Medicare intermediaries were no longer required to audit operating costs (which account for approximately 80% of all hospital costs) under "reasonable cost" principles, thus allowing them much greater time than in the past to audit GME costs. *See, e.g.*, Comments of University of Michigan Medical Center at 4, District Court Docket Item 14 (Exhibit 2). Indeed, they had special reason to be careful because, under the Secretary's 1985 regulation, their

Even more fundamentally, a "plain meaning" construction of the statute would not have prevented the Secretary from correcting any errors that might have existed. When the GME statute was enacted, no final and binding determinations of reasonable GME costs had yet been made for 1984. Thus, as the *Tulane* district court correctly observed, "[a]ny concern the Secretary might have had about the accuracy of those figures could have been addressed within the standard three-year period. . . ." *Methodist Hospitals of Memphis,* 799 F. Supp. at 1218; *see also Toledo,* Pet. App. 36a ("Had the Secretary acted promptly, there would have been no need to revisit any closed determinations, because all of the 1984 numbers were still subject to reopening for some time after the passage of the GME amendment").

Finally, the Secretary apparently proceeded on the assumption that there were no time constraints on her ability to reexamine 1984 costs. 54 Fed. Reg. 40,302 (1989). Because she believed that there may have been inaccuracies in the original audit, she decided in 1989 to conduct a reaudit of 1984, even though in many cases the 1984 year was closed. By that logic, if she decided today that

audit determination was to be used not only for 1984 reimbursement but also for the 1985 freeze.

The Secretary's assertion that amounts per resident derived from the base year audits varied from less than $10,000 to more than $100,000 proves nothing. The Secretary's reaudit determinations also resulted in such variation. *See* District Court Docket Item 14 (Exhibits 3 and 4). The variation in amounts is not surprising both because of the great variation in the sophistication and scope of GME programs and because of the methodology used to compute GME amounts per resident. A hospital's base year allowable costs (the numerator) included the costs which the hospital incurred in compensating its residents on rotation at other hospitals, but its resident count (the denominator) included only the number of residents physically located on its premises. 55 Fed. Reg. 36,064-65 (1990). Thus, hospitals that rotated residents to other hospitals necessarily had a large amount per resident, while the recipient hospitals had a relatively small amount per resident.

there may have been inaccuracies in her 1991 reaudit, she could conduct another reaudit of 1984 costs in 1998—and presumably could do so again in the year 2003, if she chose. The logic of the Secretary's position would potentially subject hospitals to a perpetual series of reaudits of 1984 costs, thus precluding the possibility of ever reaching a point of repose.

C. The Reaudit Regulation Creates Inconsistencies With the Base Year Determination and With the Cost Classifications Underlying the Prospective Payment System.

The reaudit regulation results in inconsistent determinations for the base year. The original audit established the amount actually applied to 1984. The reaudit establishes a different 1984 amount that is used for the amount per resident methodology.[18] An agency may not rationally apply the same principles to the same provider for the same period of time (1984) to reach two equally valid but different determinations of allowable costs. *See Methodist Hospitals of Memphis,* 799 F.Supp. at 1218 ("Congress could not have intended that the Secretary interpret 'recognized as reasonable' to mean two amounts for fiscal 1984"). If the first determination is final and valid (as the Secretary concedes it is), the later, inconsistent determination must necessarily be invalid. *See, e.g., American Federation of Government Employees, AFL-CIO, Local 3090 v. FLRA,* 777 F.2d 751, 760 (D.C. Cir. 1985) (Scalia, J., concurring) ("I do not think it to be true . . . that an agency is free to take inconsistent positions. . . . It is the agency's responsibility to behave in a rational (and hence reasonably consistent) fashion").

The reaudit regulation also creates inconsistency with the cost classifications that were established in the PPS

[18] The reaudit was also often based on different data than the data used for the original audit. The original audit of 1984 was based on 1984 data. However, because of the expiration of the document retention period for 1984, the reaudit of "1984" often was based in substantial part on data for a later year. 55 Fed. Reg. 36,063-64 (1990).

rates. When the Secretary issued the PPS regulations in 1983, she recognized the importance of consistently treating allowable costs as either operating or education through the consistency rule, which provided that "the costs of medical education must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion" of the PPS payment. 42 C.F.R. § 405.477(c)(2) (1983); 42 C.F.R. § 412.113(b) (1985). Thus, an allowable cost that was determined to be an operating cost in the PPS base year (1982) could not be reclassified as an education cost during 1984, and an allowable cost that was determined to be an education cost in the PPS base year could not be reclassified as an operating cost in 1984. The cost classifications established in the audit and appeals process for the PPS base year were to have binding effect for 1984. In addition, the Secretary's PPS hospital-specific rate regulations specified that the hospital-specific rate is "final, and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983" except in very limited circumstances not encompassed by the GME reaudit. 42 C.F.R. § 405.474(b)(1)(v) (1983); 42 C.F.R. § 412.71(d) (1985).

When the Secretary issued the reaudit regulations in 1989, she retroactively repealed the consistency rule for purposes of the 1984 reaudit. 42 C.F.R. § 412.113(b)(3). Consequently, during the reaudits, intermediaries frequently reclassified GME costs as operating costs for the GME base year (1984) even though the costs had been determined to be education costs in the PPS base year (1982) and thus were excluded from allowable operating costs for purposes of establishing the PPS federal rate and the PPS hospital-specific rate. 42 C.F.R. § 413.86(e)(1)(ii)(B)-(C). This of course created inconsistencies with the cost classifications used to establish the PPS rates.

The Secretary purported to deal with the inconsistency by allowing hospitals to request an adjustment to their PPS hospital-specific rates for PPS transition years (1984-

1987) still within the three-year reopening period to reflect reclassifications of costs in the GME reaudit. 42 C.F.R. § 413.86(j)(1)(i). But this failed to solve the problem of inconsistency. Under the Secretary's view, to qualify for the adjustment to the PPS hospital-specific rate, hospitals had to furnish documentation from their PPS base year (1982), 42 C.F.R. § 413.86(j)(1)(ii), which was often impossible because by the date of the GME reaudit determination (1991), the reopening and record-retention periods for 1982 had long since passed. *See Harrisburg Hosp. v. Blue Cross and Blue Shield Ass'n*, [1996 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 44,419 (HCFA Adm'r Dec.) (1996).

Even more significantly, the Secretary ensured enormous inconsistency by refusing to make any adjustment to the federal rate (which since 1988 has constituted 100% of the PPS payment) to reflect the reclassification of costs from education to operating in the GME reaudits. 54 Fed. Reg. 40,301 (1989). As a consequence, the reclassification of costs from education to operating in the GME reaudits has meant not that hospitals would be reimbursed for the costs as operating costs, but that they would receive no reimbursement for these costs (either as GME or as operating costs) even though the costs were clearly allowable Medicare costs. Thus, the Secretary's reaudit regulation overturns the principle of consistency upon which PPS was based and results in the conversion of clearly allowable costs into non-allowable costs. Absolutely nothing suggests that when Congress enacted the GME legislation it had any such intent.[19]

The reaudit regulation is an unreasonable construction of the GME statute, one that conflicts with collateral estoppel and principles of fundamental fairness, due process, and finality. Thus, even were *Chevron* applicable

[19] Indeed, the Secretary acknowledged in the preamble to the reaudit regulation that "[t]here is nothing in [the GME legislation] that addresses the recomputation of HSRs [PPS hospital-specific rates]." 54 Fed. Reg. 40,301 (1989).

and even were the GME statute ambiguous, the reaudit regulation would nonetheless fail under *Chevron* step two, as the Sixth Circuit expressly held in *Toledo*. Pet. App. 34a-37a.

III. THE REAUDIT REGULATION CONSTITUTES AN IMPERMISSIBLE RETROACTIVE CONSTRUCTION OF THE GME STATUTE.

As discussed in the preceding two sections, the Secretary's reaudit regulation fails under *Chevron*. To prevail in this case, however, the Secretary must satisfy a far more exacting standard than *Chevron*. Because of the retroactive effect of the Secretary's construction, the correct standard of review is established not by *Chevron* but by *Bowen v. Georgetown Univ. Hosp.* and *Landgraf v. USI Film Products*.

In *Georgetown* (a case, like this, involving the validity of a Medicare regulation), the Court unanimously held that an agency must possess an express grant of retroactive rulemaking authority to issue a retroactive rule. 488 U.S. at 208. In *Landgraf*, the Court reaffirmed the long-standing presumption against retroactive legislation. 114 S. Ct. at 1501, 1505. The Court applies "this time-honored presumption unless Congress has clearly manifested its intent to the contrary." *Hughes Aircraft Co. v. United States*, 65 U.S.L.W. at 4449.

The reaudit regulation has some extraordinary consequences. For purposes of the GME reaudit, the reaudit regulation effectively revoked in 1989 the reopening and record retention periods applicable to 1984, after both had expired, and repealed the consistency rule in effect in 1984. It also authorized in 1989 adjustments to the PPS hospital-specific rate for fiscal years 1984-1987, even though the regulation in effect in 1984 specified that the hospital-specific rates were "final."

The GME statute clearly did not command the Secretary to take these actions. Nor did the GME statute confer any express delegation that would authorize the Secretary to take these actions on her own initiative.

Thus, if the reaudit regulation is retroactive, it is invalid under *Georgetown* and *Landgraf*, irrespective of whether it would otherwise pass muster under *Chevron*.

The Secretary argues that the reaudit regulation is not retroactive because it adds no retroactivity not inherent in the statute itself. Brief of Defendant Appellee at 22-23. The *Tulane* court concluded that the reaudit regulation is not retroactive because the "reaudit carries no impact for actual 1984 reinmbursements and will be used only to calculate future reimbursements." Pet. App. 52a. Neither view bears analysis.

Petitioner acknowledges that there is some retroactivity inherent in the statute and does not challenge the retroactivity mandated by Congress. Congress obviously intended to replace "reasonable cost" reimbursement with a new GME payment methodology, effective for cost reporting years beginning on or after July 1, 1985. Congress also clearly intended that payment under the GME methodology would be based on the average amount recognized as reasonable per FTE resident for 1984. That provision, while involving secondary retroactivity for "future" years, does not mandate any primary retroactivity for 1984 because, when the GME statute was enacted, a long-standing process was already established under the Medicare subchapter to determine the amount recognized as reasonable for 1984.

The Secretary's regulation goes much further. It imposes a significant *new* burden on 1984 conduct. It retroactively subjected 1984 to a reaudit, after the reopening and record retention periods applicable to 1984 had expired, and retroactively reversed reimbursement principles in effect in 1984. This is most assuredly *not* retroactivity mandated by the statute.

The *Tulane* court is of course correct in stating that the 1984 reaudit affects reimbursement only for years after 1984, not reimbursement for 1984 itself. It does not follow therefrom, however, that the reaudit regulation is not retroactive. The reaudit mandated by the regulation is a reaudit of *1984* conduct, not a reaudit of 1987 or

1989 or 1992 conduct. The principle underlying the *Landgraf* presumption is that "the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place." *Landgraf*, 114 S. Ct. at 1497, *quoting Kaiser Aluminum & Chemical Corp. v. Bonjorno*, 494 U.S. 827, 855 (1990) (Scalia, J., concurring). The "conduct" here took place in 1984.

In *Landgraf*, the Court noted that "retroactivity is a matter on which judges tend to have 'sound . . . instinct[s],' . . . and familiar considerations of fair notice, reasonable reliance, and settled expectations offer sound guidance." 114 S. Ct. at 1499 (citation omitted). Application of these principles leads inexorably to the conclusion that 1984 is the proper reference point for determining whether the 1989 reaudit regulation is retroactive.

As discussed above, a limitations period serves several purposes. It protects "settled expectations" and ensures "the accuracy of the fact-finding process." *Board of Regents of the University of the State of New York v. Tomanio*, 446 U.S. at 487. It also provides "notice" of the maximum period of potential liability, promotes "repose," and protects parties "and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise." *United States v. Kubrick*, 444 U.S. at 117. "Just determinations of fact cannot be made when, because of the passage of time, the memories of witnesses have faded or evidence is lost." *Wilson v. Garcia*, 471 U.S. at 271.

Any revocation of the reopening and record retention periods applicable to 1984 *after* those periods have already expired defeats these well-established purposes—irrespective of the purpose of the reaudits. Applying the 1984 reaudit results to determine Medicare payments for 1990, instead of Medicare payments for 1984, does not in any way lessen the injustice of failing to provide clear and timely notice to a hospital that has already proven its claims for 1984 in a "final and binding" determination, 42

C.F.R. § 405.1807, that the determination is not, in fact, "final and binding" and that the hospital must once again prove its 1984 claims after the 1984 limitations period has expired. Nor does the fact that the 1984 reaudit results are not applied directly to amend 1984 reimbursement in any way ameliorate the difficulties of dealing with "cases in which the search for truth may be seriously impaired by the loss of evidence," *United States v. Kubrick*, 444 U.S. at 117, or prevent the denial of basic due proces rights caused by the failure to ensure " 'the opportunity to be heard' . . . at a meaningful time and in a meaningful manner," *Armstrong v. Manzo*, 380 U.S. at 552.

The Court's recent decision in *Hughes Aircraft Co. v. United States* clearly supports petitioner's position. At issue in *Hughes* was a 1986 statutory amendment that removed, in certain circumstances, the bar preventing a *qui tam* relator from filing suit for a false claim if the underlying information was already in the government's possession. The relator in *Hughes* filed suit in 1989, three years after the amendment's enactment, based on an alleged false claim in 1982. Prior to 1986, the relator could not have brought suit because the underlying information was in the government's possession. The relator and the government argued that the determinative event for assessing retroactivity was the filing of suit, which occurred three years *after* the 1986 amendment. This Court, however, disagreed, finding that the proper time reference was 1982, when the false claim was allegedly made. The Court concluded that the relator's suit must be dismissed because of "the absence of a clear statutory expression of congressional intent to apply the 1986 amendment to *conduct completed before its enactment*. . . ." 65 U.S.L.W. at 4451 (emphasis added).

With respect to its conclusion that 1982 furnishes the correct reference point for establishing retroactivity, the Court explained:

> The 1986 amendment would revive [the barred] action, subjecting Hughes to previously foreclosed qui

> tam litigation *much like extending a statute of limitations after the pre-existing period of limitations has expired impermissibly revives a moribund cause of action.* . . . It is simply not the case that . . . the elimination of a prior defense . . . does not "create a new cause of action" or "change the substance of the extant cause of action."

Id. at 4450 (emphasis added). The italicized words, of course, speak directly to the instant case. Here, the reaudit regulation sought to "impermissibly revive[]" an action already barred by principles of administrative finality and an "expired" limitations period. The absence of a clear statement in the statutory language mandating this result requires application of the presumption against retroactivity.[20]

The Secretary has never contended that the GME statute mandates her construction in the reaudit regulation. Rather, her position has always been that the statute is "ambiguous." Brief of Defendant Appellee at 12. Were the statute, in fact, ambiguous, that would be enough for the reaudit regulation to survive scrutiny under *Chevron* step one. But ambiguity is fatal to the Secretary's construction under *Georgetown* and *Landgraf*. The reaudit regulation is retroactive (indeed, extraordinarily so), and thus may be upheld under *Georgetown* and *Landgraf* only if the statute contains a clear statement mandating the Secretary's construction. It does not, as even the Secretary concedes, and thus the reaudit regulation is clearly invalid on retroactivity grounds.

CONCLUSION

For the foregoing reasons, the Court should reverse the judgment below.

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[20] The passage in *Hughes* precluding revival of an expired limitations period absent a clear manifestation of congressional intent to the contrary is fully in accord with *United States v. Zacks*, 375 U.S. 59 (1963). In *Zacks*, the Court ruled that a retroactive change in the tax law favorable to taxpayers did not entitle taxpayers to a refund for closed years because Congress did not expressly reopen closed years to allow taxpayers to take advantage of the retroactive change.

Respectfully submitted,

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APPENDIX

APPENDIX

STATUTES AND REGULATIONS INVOLVED

1. 42 U.S.C. § 1395ww(h) provides in relevant part:

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B of this subchapter (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct

graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) Exception

The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) Amount for first cost reporting period

For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) Amount for subsequent cost reporting periods

(i) Except as provided in clause (ii), for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer

price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(E) Treatment of certain hospitals

In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) Hospital payment amount per resident

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

(C) Medicare patient load

As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A of this subchapter.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a portion of a

period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in each case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(5) Definitions and special rules

As used in this subsection:

(A) Approved medical residency training program

The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) Consumer price index

The term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) Direct graduate medical education costs

The term "direct graduate medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) Foreign medical graduate

The term "foreign medical graduate" means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association,

or approved by such Association as meeting the standards necessary for such accreditation, or

(ii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS examination

The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(F) Initial residency period

The term "initial residency period" means the period of board eligibility plus one year, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) Period of board eligibility

(i) General rule

Subject to clauses (ii) and (iii), the term "period of board eligibility" means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) Application of 1985-1986 Directory

Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) Changes in period of board eligibility

On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985-1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985-1986 Directory, the Secretary

may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(H) Primary care resident

The term "primary care resident" means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) Resident

The term "resident" includes an intern or other participant in an approved medical residency training program.

(J) Adjustments for certain family practice residency programs

(i) In general

In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this subchapter or a State plan under subchapter XIX of this chapter) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this

subchapter if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this subchapter.

(ii) Additional requirements

A hospital's approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (i)(I)) does not exceed $10,000.

2. 42 U.S.C. § 1395oo provides in relevant part:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing wth respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") * * * if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report

* * * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received.

* * * *

Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

3. 42 U.S.C. § 1395ww(a)(1)(C) provides:

The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for

such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

4. 42 U.S.C. § 1395ww(a)(4) provides in relevant part:

For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary) * * *. Such term does not include costs of approved educational activities * * *.

5. 42 U.S.C. § 1395ww(b)(3)(A) provides:

Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

6. 42 C.F.R. § 405.481(g) (1985) provides in relevant part:

(g) *Recordkeeping requirements.* * * *, each provider that claims payment for services of physicians under this subpart must:

* * * *

(3) Retain each physician compensation allocation, and the information on which it is based, for at least four years after the end of each reporting period to which the allocation applies.

7. 42 C.F.R. § 405.1801(a)(1) (1985) provides in relevant part:

(a) *Definitions.*

* * * *

"Intermediary determination" means the following:

(1) With respect to a provider of services that has filed a cost report under §§ 405.406 and 405.453(f), the term means a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

8. 42 C.F.R. § 405.1803(a)(1) and (b) (1985) provides:

Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a

written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

* * * *

(b) *Requirements for intermediary notices.* The intermediary must include in each notice appropriate references to law, regulations, HCFA Rulings, or program instructions to explain why the intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also inform the provider of its right to an intermediary or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

9. 42 C.F.R. § 405.1807 (1985) provides:

Effect of intermediary determination.

The determination shall be final and binding on the party or parties to such determination unless:

(a) An intermediary hearing is requested in accordance with § 405.1811 and an intermediary hearing decision rendered in accordance with § 405.1831; or

(b) The intermediary determination is revised in accordance with § 405.1885; or

(c) A Board hearing is requested in accordance with § 405.1835 and a hearing decision rendered pursuant thereto.

10. 42 C.F.R. § 405.1885(a) (1985) provides in relevant part:

A determination of an intermediary * * * may be reopened with respect to findings on matters at issue in such determination * * * by such intermediary officer * * * either on motion of such intermediary officer * * * or on the motion of the provider affected by such determination * * * to revise any matter in issue at any such proceedings. * * * any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

11. 42 C.F.R. § 412.71(d) (1985) provides in relevant part:

Intermediary's determination. * * *. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

12. 42 C.F.R. § 412.113(b) (1985) provides in relevant part: [1]

Direct medical education costs. Payment for the cost of approved medical educational activities as defined in § 405.421 of this chapter is made on a reasonable cost basis * * *. For cost reporting periods beginning before October 1, 1986, the costs of medical education must be determined consistently with the treatment of such costs

[1] 42 C.F.R. § 412.113(b), as published at 54 Fed. Reg. 40,315 (1989) and corrected at 55 Fed. Reg. 299 (1990), is reproduced in its entirety in the Joint Appendix at 26.

for purposes of determining the hospital-specific portion of the transition payment rate in Subpart E of this part.

13. 42 C.F.R. § 413.86(e)(1) provides in relevant part: [2]

Determining per resident amounts for the base period— (1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

* * * *

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

[2] 42 C.F.R. § 413.86, as published at 54 Fed. Reg. 40,316-40,319 (1989) and corrected at 55 Fed. Reg. 299 (1990), is reproduced in its entirety in the Joint Appendix at 26-38.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(1) of this section.

Supreme Court, U.S.
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CLERK

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No. 96-1375

In the Supreme Court of the United States

OCTOBER TERM, 1996

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
PETITIONER

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

*ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT*

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Under a 1986 amendment to the Medicare Act, 42 U.S.C. 1395ww(h), Congress enacted a new methodology for reimbursing graduate medical education (GME) costs incurred by hospitals that participate in the Medicare program. The amendment directed the Secretary of Health and Human Services (HHS) to "determine," for each hospital's cost reporting year that began during fiscal year 1984 (the base year), the "average amount recognized as reasonable" under the Medicare Act for direct GME costs for each full-time-equivalent resident. 42 U.S.C. 1395ww(h)(2)(A). The amendment further directed the Secretary to use that base-period per-resident amount, adjusted for inflation, to calculate the hospital's GME reimbursement for reporting periods beginning on or after July 1, 1985. 42 U.S.C. 1395ww(h)(2); see 42 C.F.R. 413.86. The question presented is:

Whether the Secretary reasonably construed 42 U.S.C. 1395ww(h) to authorize the reaudit of a hospital's GME costs incurred in the base year for the purpose of determining the reimbursement due in subsequent years.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

No. 96-1375

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
PETITIONER

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-3a) is reported at 91 F.3d 57. The opinion of the district court (Pet. App. 4a-8a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on July 26, 1996. A petition for rehearing was denied on September 30, 1996. Pet. App. 9a. On December 5, 1996, and January 9, 1997, Justice Thomas extended the time within which to file a petition for a writ of certiorari to and including February 27, 1997, and the petition was filed on that date. This Court granted the petition on June 2, 1997. 117 S. Ct. 2406. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services.[1] When eligible patients receive those services, the Secretary reimburses the providers of the services under the Medicare Act and the Secretary's implementing regulations. Under the regulations, the costs of certain educational programs for health professional trainees, including programs for residents known as graduate medical education (GME) programs, are "allowable cost[s]" for which a hospital may receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a); see *Thomas Jefferson University* v. *Shalala*, 512 U.S. 504, 507 (1994).

A provider's total allowable Medicare payment is based on a "cost report[]" that it must prepare after the close of its fiscal year. 42 C.F.R. 405.1801(b); see 42 U.S.C. 1395*oo*(a). The cost report is filed with a "fiscal intermediary" (usually an insurance company) designated by the Secretary. 42 U.S.C. 1395h. The report shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. 413.20(b), 413.24(f). The intermediary analyzes the cost report, audits it if necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount to be paid for Medicare services

[1] Part B is a voluntary supplementary insurance program covering physician and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

during the reporting period. 42 C.F.R. 405.1803; see generally *Bethesda Hospital Ass'n* v. *Bowen*, 485 U.S. 399, 400-401 (1988). A provider dissatisfied with the NPR may request a hearing before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. 1395*oo*(a) and (b); 42 C.F.R. 405.1835, 405.1837. The PRRB's decision is "final," unless, within 60 days, the Secretary reverses, affirms, or modifies it. 42 U.S.C. 1395*oo*(f)(1).[2]

The Act itself does not place any limitations on the time in which a reimbursement decision at any stage of the administrative review process may be reopened to correct an error affecting the amount of reimbursement for a given cost year. By regulation, however, a determination by the intermediary or a decision of the PRRB or the Secretary that is inconsistent with applicable law, regulations, or general instructions issued by the Secretary may be reopened within three years (or at any time if there has been fraud) with respect to findings at issue in the determination. 42 C.F.R. 405.1807(b), 405.1885(a), (b) and (d).

[2] Providers may obtain judicial review of any "final decision" of the PRRB (or of the Secretary, if the Secretary exercises the right of review). 42 U.S.C. 1395*oo*(f)(1). They may also obtain expedited judicial review of any action taken by a fiscal intermediary "which involves a question of law or regulations relevant to the matters in controversy," if the PRRB determines that "it is without authority to decide the question" or fails to make a timely determination of its authority to decide the question. *Ibid.* The Board is authorized by regulation, 42 C.F.R. 405.1842(g)(2), to deny expedited judicial review if it finds that the issue on which review is sought is intertwined with disputed factual or legal issues that it is authorized to decide.

2. From 1966 through 1982, providers of services under Part A were reimbursed for Medicare-covered patient care to the extent the costs were reasonable. 42 U.S.C. 1395f(b)(1) (1982). The reasonable-cost calculation generally was based on the "cost[s] actually incurred," as long as the services were necessary. 42 U.S.C. 1395x(v)(1)(A). The Act authorized the Secretary to issue regulations defining the payment due under that statutory standard. *Ibid*; see *Shalala* v. *Guernsey Memorial Hospital*, 514 U.S. 87, 91-92 (1995). In 1983, Congress introduced a prospective payment system (PPS), which establishes fixed payment rates, based on patient diagnosis, for the operating costs of providing inpatient hospital care to program beneficiaries. See 42 U.S.C. 1395ww(d); *Good Samaritan Hospital* v. *Shalala*, 508 U.S. 402, 406 n.3 (1993). The PPS methodology was implemented over a four-year period, during which a progressively declining portion of the reimbursement was based on a hospital-specific rate derived from the hospital's actual costs in a given base year, and a gradually increasing portion was based on a federal rate reflecting regional and national standardized amounts. See 42 U.S.C. 1395ww(d)(1)(C). Costs incurred in connection with GME programs were excluded from the PPS scheme. 42 U.S.C. 1395ww(a)(4) and (d)(1)(A); *Thomas Jefferson University*, 512 U.S. at 509. Until July 1985, GME costs continued to be reimbursed on a "reasonable cost" basis.

In the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, enacted on April 7, 1986, Congress changed the method for calculating reimbursable GME costs by providing that, subject to updating for inflation, the calculation of GME costs to

be reimbursed in all subsequent years would be based on the amount of allowable GME costs incurred by the provider for a fiscal year that began between October 1, 1983, and September 30, 1984 (the base year). See Medicare and Medicaid Budget Reconciliation Amendments of 1985 (MMBRA), Pub. L. No. 99-272, Tit. IX, § 9202(a), 100 Stat. 171-175, 42 U.S.C. 1395ww(h) (the GME Amendment); see also 42 C.F.R. 413.86(e)(1)(i)(A); *Thomas Jefferson University*, 512 U.S. at 510. As the initial step in the reimbursement process, the GME Amendment provides that "[t]he Secretary shall determine [for the base year] the average amount recognized as reasonable under [the Act] for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. 1395ww(h)(2)(A). Specifically, the Secretary was directed to calculate a per-resident amount for each hospital by dividing the amount of GME costs "recognized as reasonable" for the base period of 1984 (numerator) by the number of full-time-equivalent residents working at the hospital in 1984 (denominator). To determine a hospital's GME reimbursement for any given year, the approved GME per-resident amount, adjusted for inflation, is then multiplied by the weighted number of full-time-equivalent residents in the hospital, as determined under 42 U.S.C. 1395ww(h)(4), and the hospital's Medicare patient load that year. 42 U.S.C. 1395ww(h)(3). Congress instructed the Secretary to apply the new methodology retroactively "to hospital cost reporting periods beginning on or after July 1, 1985." MMBRA § 9202(b), 100 Stat. 175, 42 U.S.C. 1395ww note.

On September 21, 1988, the Secretary published and invited comment on a proposed regulation implementing the GME Amendment. 53 Fed. Reg. 36,589.

Although the Secretary already had reimbursed most hospitals for their fiscal-year 1984 GME costs, the proposed regulation authorized fiscal intermediaries to reexamine providers' costs from the base year and to conduct a reaudit if the claimed base-year costs appeared to include "misclassified or nonallowable costs," or were "unreasonably high." *Id.* at 36,592. The Secretary explained that the agency had reason to believe some "questionable" GME costs had been "erroneously reimbursed" to providers for the base year. *Id.* at 36,591. Because the Secretary concluded that those past mistakes should not be "perpetuated" under the new GME cost-reimbursement methodology, the reauditing authority was needed to ensure an "accurate" determination of providers' base-year GME costs. *Id.* at 36,591-36,592. The Secretary believed that "the provisions of [Section 1395ww(h)] would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later." *Id.* at 36,593.

In the preamble to the final regulation, issued on September 29, 1989 (54 Fed. Reg. 40,286-40,301, 40,316; 42 C.F.R. 413.86), the Secretary reiterated that it was "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301.[3] The Secretary assured providers

[3] The Secretary pointed out that the base year for GME costs was also the first year for the new prospective payment system, and expressed the "belie[f] that GME costs were not given sufficient scrutiny at the time because of the many changes that were taking place in Medicare generally." 54 Fed. Reg. 40,301. The Secretary also was concerned that fiscal intermediaries had not been consistent in their treatment of GME costs. *Id.* at 40,302.

that, in reauditing 1984 GME costs, "no new reimbursement principles will be applied * * * [;] [r]ather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied." *Ibid.* In response to a comment that the three-year reopening limitation in 42 C.F.R. 405.1885 should not be waived for the reauditing activity, the Secretary stressed that the reaudits would not be used to recoup erroneous reimbursement for cost reports that had been settled for more than three years under the reopening regulation. 54 Fed. Reg. 40,302. Rather, they would be used to recalculate base-year costs "solely for purposes of computing the per resident amount" under the new method for reimbursing GME costs for 1985 and "subsequent years still subject to reopening." *Id.* at 40,301, 40,302.

As finally written, the reaudit regulation directs fiscal intermediaries to determine for every Medicare hospital a "base-period per resident amount." 42 C.F.R. 413.86(e)(1)(i). In making that determination, the intermediary "[v]erifies" each hospital's base-period GME costs and its average number of full-time-equivalent residents; "[e]xcludes" from those base-period GME costs "any nonallowable or misclassified costs, including those previously allowed under * * * this chapter"; and, upon the hospital's request, includes GME costs that were misclassified as operating costs during the base period. 42 C.F.R. 413.86(e)(1)(ii)(A)-(C).[4] If a cost report for the GME base

[4] The regulation also provides that, if the reaudit results in a disallowance based on costs that should have been classified as operating rather than educational costs, a hospital may request an upward adjustment to its hospital-specific rate during the four-year PPS transition period to reflect those higher operat-

period is no longer subject to reopening under Section 405.1885, however, the regulation provides that "the intermediary may modify the hospital's base-period GME costs solely for purposes of computing the per resident amount." 42 C.F.R. 413.86(e)(1)(iii). The regulation also authorizes a hospital to appeal to the PRRB the intermediary's determination of the base-period per-resident amount within 180 days of the date of the intermediary's notice of its determination. 42 C.F.R. 413.86(e)(1)(v).

3. Petitioner, St. Paul-Ramsey Medical Center, Inc., is a teaching hospital that provides Medicare services. J.A. 11 (Compl. ¶ 10). On February 28, 1986, petitioner received an NPR from its fiscal intermediary for its cost-reporting year ending December 31, 1984. J.A. 17 (Compl. ¶ 35). The NPR reflected total GME costs of $9,892,644. Pet. App. 2a.[5]

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ing costs. 42 C.F.R. 413.86(e)(1)(iv) and (j)(1)(i). Conversely, the regulation provides that, in order to increase the GME "base-period per resident amount," a hospital may request that the intermediary include GME costs that previously were misclassified as operating costs, as long as the hospital likewise requests an adjustment of its hospital-specific rate to reflect the reclassification. 42 C.F.R. 413.86(e)(1)(ii)(C) and (j)(2)(i). For purposes of obtaining reimbursement, both adjustments were made effective for cost-reporting periods that were still subject to reopening under the three-year period set forth in Section 405.1885. See 54 Fed. Reg. 40,300-40,302 (1989); 42 C.F.R. 413.86(j)(1)(i) and (iii), and (2)(i) and (iii). The Secretary explained that, in both situations in which hospital-specific rates could be adjusted at the hospital's request, "the recomputation works to the benefit of the hospitals involved." 54 Fed. Reg. 40,301 (1989).

[5] Petitioner apparently did not appeal that NPR to the PRRB. Accordingly, as of March 1, 1989, three years and one day after the NPR was issued, the intermediary's determination was no longer subject to reopening for purposes of altering

In late 1990, fiscal intermediaries began to implement the new methodology for reimbursing GME costs under the GME Amendment by reviewing and, where appropriate, reauditing the base-year cost reports of a number of teaching hospitals that provide Medicare services, including petitioner. On February 18, 1991, petitioner's fiscal intermediary notified petitioner that, upon redetermination, its base-period per-resident amount was $46,254, which was computed by dividing total allowable GME costs for the base period of $5,494,955 by 118.8 full-time-equivalent residents. Admin. Rec. 124-125. Thus, the redetermined amount of petitioner's allowable GME costs for the base year was $4,397,689 less than the $9,892,644 in GME costs that the intermediary had approved in petitioner's NPR. Pet. App. 2a. Although it was evident that petitioner had received excessive reimbursement for 1984 GME costs, no recoupment action was taken against it by the intermediary or the Secretary because the total amount of reimbursement based on petitioner's 1984 cost report had been finally determined. Instead, the intermediary notified petitioner that it would use the reaudited GME cost amount solely to determine petitioner's reimbursable GME amount for all cost-reporting years beginning on or after July 1, 1985, for which the three-year reopening period had not already elapsed. Pet. 7-8; see 42 C.F.R. 413.86(e)(1)(iii).

On August 13, 1991, petitioner appealed the intermediary's notice of the base-period per-resident amount to the PRRB. Pet. 8; Admin. Rec. 119. Petitioner challenged 169 adjustments that were made by the intermediary in the reaudit. Admin. Rec. 108-114,

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the total amount of reimbursement to petitioner for that year. 42 C.F.R. 405.1807, 405.1885(a).

119-120. On February 28, 1994, petitioner withdrew all of its challenges to the intermediary's reaudit, except a challenge to the statistical methodology used by the intermediary to allocate physician teaching costs to medical school students. *Id.* at 20-21 & n.1. Petitioner also challenged the facial validity of the GME regulation authorizing the reaudit, arguing that the GME Amendment required the Secretary to determine petitioner's base-period per-resident amount by using the amount that was reflected in petitioner's NPR for the base period, reimbursed by the Secretary, and no longer subject to administrative reopening. *Id.* at 20. On September 16, 1994, petitioner notified the PRRB that the statistical issue had been settled in principle. *Id.* at 3-4.[6] On September 28, 1994, the PRRB concluded that it lacked authority to invalidate the GME regulation, thereby allowing petitioner to seek expedited judicial review under 42 U.S.C. 1395*oo*(f)(1). Admin. Rec. 1-2; see note 2, *supra*.

4. Petitioner filed suit in the United States District Court for the District of Minnesota challenging the validity of the GME reaudit regulation. On the parties' cross-motions for summary judgment, the district court upheld the regulation. Pet. App. 4a-8a.

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[6] On September 21, 1994, the parties entered into a formal settlement agreement under which the intermediary agreed to reconsider petitioner's physician teaching costs for medical students. On January 13, 1995, the intermediary notified petitioner that it had revised petitioner's base-period per-resident amount from $46,254 to $49,805.29, calculated by dividing GME base-year costs of $5,916,868 by 118.8 full-time-equivalent residents. See Letter from Leonard Thies, Audit Manager, Blue Cross and Blue Shield of Minnesota, to John Bloom, Reimbursement Manager, St. Paul-Ramsey Medical Center (Jan. 13, 1995).

The court observed (*id.* at 7a) that petitioner's arguments supporting its challenge to the reaudit regulation had been considered and rejected by the United States Court of Appeals for the District of Columbia Circuit in *Administrators of the Tulane Educational Fund* v. *Shalala*, 987 F.2d 790 (1993), cert. denied, 510 U.S. 1064 (1994), and by the District Court for the Northern District of Ohio in *Toledo Hospital* v. *Secretary of Health & Human Services*, No. 3:94CV7080 (June 23, 1995), rev'd, 104 F.3d 791 (6th Cir. 1997), petition for cert. pending, No. 96-2046 (filed June 25, 1997).[7] The court found those decisions "persuasive, thorough, well-reasoned and indistinguishable from the present case." Pet. App. 8a. Accordingly, the court "adopt[ed]" the analyses of those decisions and granted summary judgment in favor of the Secretary. *Ibid.*

5. The court of appeals affirmed. Pet. App. 1a-3a. The court explained that "the Secretary's reaudit regulations must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*." *Id.* at 3a. Thus, the court concluded that "[t]he statute is ambiguous, and the reaudit regulations are not an exercise in retroactive rulemaking." *Ibid.* The court observed that, "[w]hile it would have been far preferable had the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements, the substance of the regulations is clearly reasonable." *Ibid.*

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[7] The opinions of the Sixth Circuit in *Toledo* and of the D.C. Circuit in *Tulane* are reproduced in the certiorari petition in this case at Pet. App. 20a-37a and 38a-54a, respectively. Hereafter, references to the opinions in those cases are to the Pet. App.

SUMMARY OF ARGUMENT

I. The familiar two-step analysis of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984), requires that, if Congress has not "directly spoken to the precise question at issue," courts must sustain an agency's interpretation of an Act of Congress so long as it is "based on a permissible construction of the statute." Moreover, where, as here, the Act confers legislative rulemaking authority on the Secretary, the regulations "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." See *Sullivan* v. *Zebley*, 493 U.S. 521, 528 (1990) (quoting *Chevron*, 467 U.S. at 843-844). Here, Congress has not spoken to the precise question at issue, and the Secretary's interpretation of 42 U.S.C. 1395ww(h)(2)(A), as reflected in the reaudit rule, is plainly reasonable. *A fortiori*, it is not "arbitrary, capricious, or manifestly contrary to the Act."

A. The text of Section 1395ww(h)(2)(A) is ambiguous. The Medicare Act provides that the Secretary "shall determine" for a hospital's base year of 1984 "the average amount recognized as reasonable under this subchapter" for GME costs for each full-time-equivalent resident. 42 U.S.C. 1395ww(h)(2)(A). That language—which does not specify any methodology for determining a hospital's reasonable base-year GME costs—is subject to varying interpretations. Thus, the phrase "recognized as reasonable under this subchapter" could refer to an amount of base-year GME costs that *is* recognized as reasonable under the substantive standards of reasonableness in the Medicare Act and implementing regulations as applied by the Secretary through the reauditing process. Alternatively, it could refer to an amount of

base-year GME costs that *was* recognized as reasonable in connection with the intermediary's prior issuance of an NPR based on the provider's cost report.

Under the Act, the Secretary has wide authority to issue regulations to define reasonable costs. 42 U.S.C. 1395x(v)(1)(A), 1395hh. In light of that long-standing authority, the Secretary reasonably construed the GME Amendment to permit a reexamination of base-year GME costs to ensure that they are "recognized as reasonable" under the reasonable-cost principles of the Act and implementing regulations in effect during the base year. Petitioner's contrary contention—that the GME Amendment clearly prohibits such reexamination and thus requires perpetuation of errors from settled cost years into all future cost years—lacks merit.

B. The reaudit rule is based on a permissible interpretation of the Act and is not arbitrary or capricious. It furthers Congress's intent in the GME Amendment to limit future Medicare reimbursements for GME costs. The original reviews of base-year GME costs, which were conducted at the time major changes were taking place in the Medicare program, included substantial overpayments resulting from misclassified and nonallowable costs. Thus, the reaudit rule reflects the Secretary's entirely sensible view that Congress would not have wanted to cement prior errors into all future GME payments simply because reimbursements in certain prior years based on those errors cannot be corrected.

The reaudit rule is consistent with principles of fairness and repose. The Secretary's regulation does not upset settled expectations with respect to past reimbursements, but instead permits a reexamination of base-year GME costs solely for purposes of de-

termining subsequent reimbursement for cost years still subject to administrative review or reopening. Further, the rule is not invalid on its face because of the possibility that hospitals (albeit apparently not petitioner) may have discarded certain records relating to base-year GME costs prior to the time of the reaudit. The proposed rule issued in 1988 and the final rule issued in 1989 put providers on notice that their GME costs might be reaudited. In any event, the Secretary reasonably responded to the concern about records by providing alternative means by which providers could prove their entitlement to Medicare reimbursement. In addition, the reaudit rule reasonably accorded hospitals the opportunity to request an upward adjustment of their hospital-specific rates during the PPS transition period in the event the reaudit revealed that base-year GME costs should have been classified as operating costs.

II. The reaudit rule is not impermissibly retroactive under this Court's decisions in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988), and *Landgraf* v. *USI Film Products*, 511 U.S. 244 (1994). The reaudit rule does not permit the Secretary to reopen administratively settled cost reports in order to recoup GME overpayments to providers during those closed periods. Nor is the Secretary's rule rendered retroactive simply because "it draws upon antecedent facts for its operation." *Landgraf*, 511 U.S. at 270 n.24. Moreover, because the rule does not reopen settled cost years for purposes of recouping reimbursement, the rule does not impermissibly increase a hospital's liability or create a new cause of action for past conduct. Finally, the reaudits apply only those reasonable-cost principles that were in effect during

the base year. Thus, the reaudit rule does not apply new legal standards to prior conduct.

ARGUMENT

I. THE GME REAUDIT REGULATION REFLECTS A PERMISSIBLE CONSTRUCTION OF THE GME AMENDMENT

The GME Amendment to the Medicare Act directs the Secretary to "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. 1395ww(h)(2)(A). The issue in this case is whether the Secretary reasonably construed that provision to permit a reexamination of the reasonable costs of GME training programs in the 1984 base year for the purpose of computing the amounts due in subsequent years.

It is axiomatic that, if a court determines that a congressional enactment speaks directly "to the precise question at issue," the court "must give effect to the unambiguously expressed intent of Congress." *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984). If "the statute is silent or ambiguous with respect to the specific issue," however, the court must sustain an agency's interpretation and implementing regulations if they are "based on a permissible construction of the statute." *Id.* at 843. In this case, moreover, Congress has conferred legislative rulemaking authority on the Secretary in the implementation of the Medicare Act. See 42 U.S.C. 405(a) (as incorporated in the Medicare program by 42 U.S.C. 1395ii), 1395x(v)(1)(A), 1395hh; *Good Samaritan Hospital* v.

Shalala, 508 U.S. 402, 418-419 & n.13 (1993); *Sullivan* v. *Zebley*, 493 U.S. 521, 525 n.2, 528 (1990); *Heckler* v. *Campbell*, 461 U.S. 458, 466 (1983). In such a situation, regulations must be sustained unless they are "arbitrary, capricious, or manifestly contrary to the statute." *Sullivan* v. *Zebley*, 493 U.S. at 528 (quoting *Chevron*, 467 U.S. at 843-844). Here, far from being arbitrary or capricious, the readuit regulation is eminently reasonable and fully consistent with the Act.

A. Section 1395ww(h)(2)(A) Is Ambiguous With Respect To The Manner In Which The Secretary May Calculate For The Base Year An Average Per-Resident Amount Of GME Costs

1. *The Secretary's approach is consistent with the text of Section 1395ww(h)(2)(A)*

The GME Amendment provides that, for all cost years beginning on or after July 1, 1985, the determination of GME costs reimbursable under Medicare Part A is based on the amount of a provider's average per-resident GME costs for the base year, updated for inflation and multiplied by the number of the hospital's current full-time-equivalent residents and its Medicare patient load. 42 U.S.C. 1395ww(h)(3). The GME Amendment directs the Secretary to calculate the per-resident amount by dividing the amount of GME costs "recognized as reasonable" under the Medicare Act for the base year (numerator) by the number of full-time-equivalent residents working at the hospital in the base year (denominator). 42 U.S.C. 1395ww(h)(2)(A). Despite the obvious significance of a hospital's "reasonable" base-year GME costs, Congress did not specify the manner by which the Secretary should determine those costs. Instead, the GME Amendment simply provides, in general

terms, that the Secretary "shall determine" the average amount recognized as reasonable. *Ibid.*

The language at issue in this case—"recognized as reasonable under this subchapter"—is amenable to at least two different constructions. See *Tulane*, Pet. App. 48a ("[T]he relevant phrase 'amount recognized as reasonable under this subchapter' *is* on its face ambiguous."). The Secretary interprets the phrase to mean that the determination of the average amount of a provider's reasonable base-year GME costs must be consistent with the reasonableness standards in effect during the base year under the Medicare Act and implementing regulations. Under that construction, the Secretary may compute an average per-resident base-year amount that is "recognized as reasonable under this subchapter" by reauditing hospitals' cost reports for the base year to ensure that the base-year costs comport with the reasonableness standards of the Medicare Act in effect during the base year. In that manner, misclassified or nonallowable costs paid to providers in the base year do not continue to be paid in future years. Petitioner argues (Br. 19-23), by contrast, that the amount of base-year GME costs "recognized as reasonable under this subchapter" must mean the amount of GME costs that were included in the hospital's NPR (or a subsequent PRRB decision) for the base year, if that intermediary determination (or PRRB decision) is not subject to reopening under the three-year period prescribed by the Secretary's regulations, 42 C.F.R. 405.1807 and 405.1885(a). In petitioner's view, Congress by statute intended to prohibit the Secretary from reauditing base-year GME costs if the reopening period prescribed by mere regulation had expired with respect to the base year. Under that construction, any errors

in base-year reimbursements must be permanently carried forward by the Secretary in reimbursements for GME costs in all subsequent years. Nothing in the GME Amendment compels that anomalous result.

In requiring the Secretary to reimburse GME costs under the new methodology, Section 1395ww(h)(2)(A) requires the Secretary to consider only those base-year GME costs "recognized as reasonable" under the Medicare Act. It does not prescribe, however, what costs should be "recognized as reasonable," how the Secretary should ascertain those costs, or when the reasonableness of the costs should be regarded as "recognized." At bottom, "Congress has not directly addressed the precise question at issue" (*Chevron*, 467 U.S. at 843)—whether Congress intended for the Secretary to reach her determination of reasonable costs by using an amount that already had been reimbursed by the Secretary in the base year, or by using an amount that the Secretary now determines should be recognized as reasonable under base-year cost principles. As the D.C. Circuit observed in *Tulane*, "[t]he statutory text certainly does not address this administrative dilemma directly," and there is "no convincing evidence, direct or indirect, that Congress meant to prohibit corrective reauditing of the 1984 GME cost figures." Pet. App. 46a.[8]

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[8] In disagreeing with the D.C. Circuit's conclusion in *Tulane* that the text of the GME Amendment is ambiguous, the Sixth Circuit in *Toledo* expressed the view that "*Chevron* instructs courts to accept a reasonable administrative interpretation of a statute" only when "Congress *intentionally* leaves gaps and ambiguous terms in a statute for the agency to flesh out." Pet. App. 29a (emphasis added). As the Court in *Chevron* made clear, however, courts should accord deference to reasonable policy choices that "Congress itself either *inadvertently* did not resolve, or intentionally left to be resolved by the agency charged with the administration of the statute in light of everyday realities." 467 U.S. at 865-866 (emphasis added). Thus, the proper inquiry is whether Congress, in enacting the GME Amendment, unambiguously expressed its intent to prohibit the Secretary from correcting past errors in administratively settled cost years.

Petitioner similarly argues (Br. 29 n.9) that "the error of the Secretary's construction" is demonstrated by the absence of legislative history indicating that Congress specifically intended for the Secretary to correct for errors in the GME base year after expiration of the reopening period under Section 405.1885(a). This Court, however, has rejected that contention. See *Chevron*, 467 U.S. at 862 (noting that legislative history of 42 U.S.C. 7502(b)(6) (1982) is "unilluminating" and "silent on the precise issue before us").

The ambiguity in the statutory phrase "amount recognized as reasonable under this subchapter" stems from Section 1395ww(h)(2)(A)'s use of the past participle "recognized." As the D.C. Circuit in *Tulane* explained, that term permits "alternative temporal readings." Pet. App. 49a (quoting *United States Dep't of Treasury* v. *FLRA*, 960 F.2d 1068, 1072 (D.C. Cir. 1992)); see also Bergen Evans & Cornelia Evans, *A Dictionary of Contemporary American Usage* 353 (1957) ("the form [of past participles] itself does not express time and may be used in speaking of the present"). Thus, "it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three-year reopening process. It might just as well have permitted the Secretary the option of using a figure that would be 'recognized as reasonable under this title' at a later time after more careful assessment." *Tulane*, Pet. App. 48a-49a.

Other provisions of the Medicare Act similarly use the phrase "recognized as reasonable" in a way that highlights its flexibility. See 42 U.S.C. 1395x(v)(1)(A) (permitting the Secretary to "provide for the establishment of limits [of certain costs] *to be* recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services" (emphasis added)) (discussed in *Good Samaritan Hospital*, 508 U.S. at 412); 42 U.S.C. 1395uu(c)(1)(B) (providing that a hospital's "transitional allowance" with respect to the closing or converting of underutilized hospitals "shall recognize" "the outstanding portion of actual debt obligations *previously* recognized as reasonable for purposes of reimbursement under this subchapter" (emphasis added)). As the D.C. Circuit observed in *Tulane*, those provisions "suggest that the phrase 'recognized as reasonable,' by itself, does not tell us whether Congress means to refer the Secretary to action already taken or to give directions on actions about to be taken. Context is all, and in this case, * * * the use of the 1984 figures for the indefinite future cautions us against a reading of the phrase that allows no elbow room for adjustments based on prior miscalculations or errors." Pet. App. 49a-50a.

Indeed, petitioner concedes that the word "recognized" is temporally indefinite in this setting. When Congress enacted the GME Amendment in April 1986, most NPRs for fiscal year 1984 were still subject to reopening under the Secretary's regulations. Petitioner therefore agrees that, in directing the Secretary to determine an amount of base-year GME costs "recognized as reasonable," Section 1395ww(h)(2)(A) does not refer to just those GME costs that were *previously* reflected in the hospital's

base-year cost report or NPR and were already reimbursed by the Secretary. See Br. 22; see also *Toledo*, Pet. App. 30a ("[T]he use of the past participle 'recognized' does not restrict the Secretary to using numbers that had been finally determined prior to the passage of the GME amendment, as all of the base-year determinations were still subject to administrative reopening in 1986."). Petitioner's acknowledgement that the phrase "recognized as reasonable under this subchapter" is not restricted to *previously* reimbursed costs makes clear that the statutory text permits the Secretary to reexamine base-year costs in implementing the GME Amendment. Nothing in the text of that phrase prohibits the Secretary from pursuing the particular manner she has chosen for conducting that reexamination.

The structure of the GME Amendment, and of the Act as a whole, supports the Secretary's approach in other respects as well. The most natural reading of the GME Amendment's mandate to determine an average amount of base-year GME costs "recognized as reasonable under this subchapter" is that the phrase "under this subchapter" modifies the word "reasonable," which immediately precedes it. In other words, a hospital may obtain reimbursement for GME costs only if they are reasonable within the meaning of the Medicare Act. See, *e.g.*, 42 U.S.C. 1395f(b)(1). Although the Act does not prescribe specific procedures for calculating reasonable costs, Congress has granted the Secretary broad authority to promulgate regulations setting forth the methods to determine reasonable costs and the items to be included in reimbursable services. 42 U.S.C. 1395x(v)(1)(A), 1395hh(a)(1); see also 42 U.S.C. 405(a) (as incorporated by 42 U.S.C. 1395ii), 1302(a). That authority

permits the Secretary to promulgate the reaudit regulation to ensure that future payments for GME costs do not include unreasonable costs previously paid to hospitals.[9]

Moreover, by providing that the Secretary "shall determine" an average amount of base-year GME costs recognized as reasonable under the Medicare Act, the GME Amendment reflects Congress's expectation that the Secretary would, in the future, make a fresh determination of reasonable base-year GME costs, whether under existing, revised, or new regulations. As the D.C. Circuit in *Tulane* explained, the phrase "shall determine" is "activist language suggest[ing] that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations." Pet. App. 49a n.6.[10] Further, given the statu-

[9] Arguing that the Secretary "seems to be searching for a statutory basis * * * to issue the reaudit regulation," petitioner asserts (Br. 26 n.8) that the Secretary "expressly disavowed reliance on her general rulemaking authority" under Section 1395hh(a)(1) to support the reaudit regulation. The only support for that contention, however, is petitioner's reference to the Secretary's statement in the preamble to the final rule that "the agency is not relying on our general grant of rulemaking authority to support *retroactive application*" of the GME Amendment to cost-reporting periods beginning on or after July 1, 1985, "but, rather, on a specific congressional enactment, that is, [the GME Amendment]." 54 Fed. Reg. 40,314 (1989) (emphasis added). Moreover, the Secretary *expressly* relied on her general rulemaking authority in promulgating the reaudit rule. See *id.* at 40,315 (citing, *inter alia*, 42 U.S.C. 1302, 1395x(v), 1395hh, and 1395ww); see also 42 C.F.R. 413.86 (citing 42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

[10] Petitioner argues (Br. 21 n.6) that "determine" is only an "activist" word under an "activist" construction of the Act.

tory directive to create a new payment methodology that would govern subsequent payments for GME costs, the Secretary reasonably found it "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301 (1989). Accordingly, the Secretary's decision to implement the new payment methodology by reauditing base-year costs to ensure that only reasonable costs are included in the base for future years is entirely consistent with the statutory directive to determine an amount "recognized as reasonable" under the Medicare Act.

2. *Petitioner's contention that the text of Section 1395ww(h)(2)(A) forecloses the Secretary's approach is without merit*

In contending that the phrase "amount recognized as reasonable under this subchapter" is unambiguous, petitioner relies not on the quoted words, or on other statutory text. Instead, petitioner relies principally

According to petitioner (*ibid.*; emphasis omitted), the directive in the GME Amendment to "determine" an average base-year per-resident amount by dividing base-year GME costs "recognized as reasonable" by the number of base-year full-time equivalent residents "does not authorize the Secretary to redetermine" those base-year costs. As explained above, however, the statutory language "recognized as reasonable under this subchapter" is temporally ambiguous and does not clearly refer to any particular methodology or point in time for recognizing reasonable base-year GME costs. Moreover, in observing that the GME Amendment used "activist language," *i.e.*, not passive terminology, in directing the Secretary to "determine" an amount of reasonable base-year GME costs, the *Tulane* court meant only that "it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula." Pet. App. 49a n.6.

(Br. 18-23) on regulations issued by the Secretary, 42 C.F.R. 405.1885(a) and 405.1807, under which a final determination of the total amount of reimbursement due for a given cost year may be reopened only within three years of that final determination. Thus, in petitioner's view, if the final determination of the total amount of reimbursement due a particular hospital for the 1984 cost year was made more than three years earlier, the reasonable costs for that year are altogether immune from reexamination, even if the reexamination occurs solely to determine a reasonable foundation for GME reimbursements in future years. Nothing in the phrase "recognized as reasonable," or elsewhere in the text or legislative history of the GME Amendment, however, suggests that Congress meant to import a mere regulatory limitation into the GME Amendment itself.

The fact that the three-year limitation on reopening on which petitioner relies is not mandated by the Act, but is imposed only by regulation, is significant for another reason as well. Even under petitioner's theory, the Secretary could have achieved the same result as that provided for under the reaudit regulation by expressly amending the reopening regulation to lengthen the reopening period for base-year GME costs solely for purposes of determining the proper amount of reimbursement due in subsequent years under the GME Amendment, without disturbing the amount of reimbursement that the provider already had received for services that were rendered in the base year. Compare 42 C.F.R. 413.86(e)(1)(iii) ("If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the

per resident amount.").[11] If that special treatment of GME costs from the usual operation of the reopening limitation under the regulations would not violate the GME Amendment, there is no reason why the approach taken by the Secretary—which is identical in substance—should be regarded as fundamentally inconsistent with the Amendment.

Petitioner also argues (Br. 23-26) that, had Congress intended the Secretary to adopt a new rule defining reasonable base-year costs, Congress explicitly would have provided for such authority in the GME Amendment as it did with respect to other matters, such as the determination of full-time-equivalent residents in Section 1395ww(h)(4). By the time the GME Amendment was enacted, however, the Secretary's authority to promulgate regulations defining the methodology for determining reasonable costs was already established in the Medicare Act. See 42 U.S.C. 1395x(v)(1)(A), 1395hh(a)(1); *Good Samaritan Hospital*, 508 U.S. at 412. As the D.C. Circuit observed in *Tulane*, because "the concept of reasonable costs already was a mainstay of Medicare statutes and regulations, * * * there was no need to establish any new rulemaking authority for its determination." Pet. App. 47a n.5.

In Section 1395ww(h)(4)(A), by contrast, Congress addressed a new issue and provided that the Secretary

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[11] Indeed, in promulgating the reaudit rule, the Secretary effectively lengthened the reopening period under Section 405.1885(a) for the benefit of hospitals so that they could request a redetermination of their operating costs in the event that the GME reaudit revealed that previously claimed costs should have been classified as operating costs. See 54 Fed. Reg. 40,300-40,302 (1989); 42 C.F.R. 413.86(j)(1)(i); see also note 4, *supra*.

"*shall* establish rules" for the computation of the number of full-time-equivalent residents in an approved program. Thus, Congress did not merely "authorize" the Secretary to adopt such rules, as petitioner maintains (Br. 23); Congress required that action. Congress's decision to include a new statutory *mandate* to issue rules in that one instance in no way suggests that Congress intended to eliminate the Secretary's preexisting statutory authority to issue procedural and substantive rules for reexamining reasonable costs in other situations. Nor is there anything else in the text or legislative history of the GME Amendment suggesting that Congress intended to restrict the Secretary's authority to issue new regulations for the purpose of determining reasonable base-year GME costs. For those reasons, the Secretary correctly interpreted the GME Amendment to permit the issuance of a new rule to govern reaudit of base-year GME costs to eliminate nonallowable or misclassified costs under the new reimbursement methodology to be applied in future years.[12]

Petitioner similarly contends (Br. 27-29) that, had Congress intended the Secretary to reexamine the reasonableness GME costs in the base year, the GME

[12] Petitioner further argues (Br. 32-34) that the Secretary purports to derive authority to issue the reaudit rule simply from the GME Amendment's failure expressly to prohibit the Secretary from reauditing base-year costs. That is incorrect. The reaudit rule is an application of the Secretary's broad authority under the Medicare Act to promulgate regulations to establish procedures and methods of proof (42 U.S.C. 405(a), as incorporated by 42 U.S.C. 1395ii) and to define reasonable costs (42 U.S.C. 1395x(v)(1)(A), 1395hh). The Secretary's decision to invoke that preexisting authority in this situation, moreover, is reinforced by the purpose of the GME Amendment. See also note 8, *supra*.

Amendment would have addressed various administrative issues associated with implementation of the reaudit rule, such as the cost principles to be applied and the availability of adequate documentation to conduct the reaudits. That contention, however, presupposes that Congress knew that the Secretary's prior reimbursements for GME costs contained substantial overpayments and that, based on the knowledge of those prior errors, Congress would have dictated a specific methodology for the reaudits. Given that neither the text nor the history of the GME Amendment reveals Congress's views on the subject, the Secretary considered the matter "not in a sterile textual vacuum, but in the context of implementing policy decisions in a technical and complex arena," *Chevron*, 467 U.S. at 863, and accordingly fashioned the reaudit regime consistent with the Secretary's responsibilities for administering the Medicare Act. See 42 U.S.C. 1395h(a) (authorizing the Secretary to use fiscal intermediaries "to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part"); 42 C.F.R. 421.100(c) (describing audit function of intermediaries). Accordingly, "since the GME Amendments were enacted for the purpose of establishing a new and presumably more accurate methodology for reimbursing GME costs, the most natural assumption to be drawn from the statutory silence on the subject would be that Congress did not mean to preclude HHS from correcting past mistakes in the 1984 figure which would govern subsequent payments." *Tulane*, Pet. App. 46a.

Petitioner also errs in contending (Br. 30-32) that the reaudit regulation conflicts with the principle that "identical words used in different parts of the

same act are intended to have the same meaning." *Sorenson* v. *Secretary of Treasury*, 475 U.S. 851, 860 (1986). Petitioner points to two provisions of the Medicare Act limiting reimbursable costs to a base year that the Secretary chose not to subject to a mandatory reaudit. Those provisions, however, do not contain language identical to the GME Amendment.[13] In any event, those provisions address different contexts under the Medicare program, and the fact that the Secretary, as a matter of policy, did not consider a reaudit necessary for base-year calculations in those other contexts does not mean, as petitioner contends, that the phrase "recognized as reasonable under this subchapter" unambiguously forecloses such reaudits where, as here, the Secretary does consider them to be necessary. *Samaritan Health Sys.* v. *Shalala*, No. Civ. 95-1032 (D. Ariz., Aug. 15, 1997), slip. op. 12 (rejecting the same objection to the reaudit regulation, on the ground that

[13] Compare 42 U.S.C. 1395ww(h)(2)(A) ("The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.") with 42 U.S.C. 1395ww(a)(1)(C) ("The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services * * * recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.") and 42 U.S.C. 1395ww(b)(3)(A)(i) ("[T]he term 'target amount' means, with respect to a hospital for a particular 12-month cost reporting period * * * in the case of the first such reporting period * * *, the allowable operating costs of inpatient hospital services * * * recognized under this subchapter for such hospital for the preceding 12-month cost reporting period.").

"there is nothing inconsistent about reacting to different situations differently"); see also *Chevron*, 467 U.S. at 864 ("[T]he fact that the agency has adopted different definitions in different contexts adds force to the argument that the definition itself is flexible.").[14]

B. The Reaudit Regulation Is Reasonable

For the reasons set forth in Point A, the text of Section 1395ww(h)(2)(A) is ambiguous and does not, on its face, bar the Secretary from implementing the GME Amendment in the way that she did. A court interpreting an ambiguous provision of a statute

[14] Petitioner suggests (Br. 15, 31) that the Secretary's reaudit rule conflicts with the D.C. Circuit's decision in *Georgetown University Hospital* v. *Bowen*, 862 F.2d 323 (1988) (*Georgetown II*). In fact, however, the Secretary's reaudit rule completely accords with the *Georgetown II* decision. That case involved the Secretary's implementation of Section 1395ww(b)(3)(A)'s direction to the Secretary to determine hospital-specific rates for the four-year PPS transition period calculated on the basis of a base year. The court invalidated HHS's regulation providing that, when a hospital successfully challenged an intermediary's estimation of the base-period costs, the finally approved figure would not be applied to the year being challenged. 862 F.2d at 325. The court in *Georgetown II* held that the phrase "allowable operating costs * * * recognized under this subchapter" in Section 1395ww(b)(3)(A) requires HHS to apply a final administrative or judicial decision on the allowability of particular costs to the year under appeal. *Id.* at 326-328. As the D.C. Circuit later explained in *Tulane*, "HHS is in no way attempting here to 'effectively cement[] unlawful calculations * * * by largely insulating them from review,' as it was in *Georgetown II*. Just the opposite. It is attempting [in the reaudit rule] to ensure that misclassified and nonallowable costs approved in NPRs for 1984 are *not* cemented indefinitely into future GME cost reimbursements." Pet. App. 48a (citation omitted).

administered by an agency must defer to the agency's interpretation if that interpretation is "reasonable." *Chevron*, 467 U.S. at 844. As this Court has explained, "when an agency is charged with administering a statute, part of the authority it receives is the power to give reasonable content to the statute's textual ambiguities." *Department of Treasury* v. *FLRA*, 494 U.S. 922, 933 (1990). "That is a task infused with judgment and discretion, requiring the 'accommodation of conflicting policies that were committed to the agency's care.'" *Ibid.* The principle of deference to administrative interpretations

> has been consistently followed by this Court whenever decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations.

Chevron, 467 U.S. at 844. Judicial deference is particularly warranted when, as here, the statute establishes "a complex and highly technical regulatory program," in which eligibility determinations "necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns." *Pauley* v. *BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991); see also *Thomas Jefferson University* v. *Shalala*, 512 U.S. 504, 512 (1994). The Secretary's decision to implement the GME Amendment by reexamining base-year GME costs to ensure that they include only reasonable costs reflects the expert agency's interpretation and implementation of an ambiguous provision of a complex statute. The reaudit regulation attempts to reconcile the Secretary's existing regulatory regime with the obvious desire of Congress that the GME Amendment's new payment methodology would be based on "reasonable" base-year costs, 42 U.S.C. 1395ww(h)(2)(A). The only remaining inquiry is whether the agency's interpretation is "based on a permissible construction of the statute." *Auer* v. *Robbins*, 117 S. Ct. 905, 909 (1997) (quoting *Chevron*, 467 U.S. at 842-843).

To answer that inquiry, a court should examine whether the agency's interpretation is "reasonable," *Pauley*, 501 U.S. at 699, in the sense that it is "rational and consistent with the statute." *Sullivan* v. *Everhart*, 494 U.S. 83, 89 (1990) (quoting *NLRB* v. *United Food & Commercial Workers Union, Local 23*, 484 U.S. 112, 123 (1987)). Indeed, that approach not only gives proper respect to the agency's congressionally assigned function, but it also confines the courts to their proper role by directing disputes over policy to the politically accountable branches of government. *Chevron*, 467 U.S. at 864-865. That approach is especially appropriate here, because the text of the statutory provision does not purport to address, much less strike a balance between, administrative finality and ensuring that unreasonable and misclassified costs are not perpetuated in future reimbursements to Medicare providers.

1. ***The Secretary's regulation furthers the purpose of the GME Amendment***

The Secretary's interpretation of the GME Amendment is manifestly rational. Section 1395ww(h) establishes a new payment methodology for reimbursing GME costs. Under that new methodology, a hospital's base-year GME costs significantly influence Medicare payments for GME costs in all subsequent years, regardless of the hospital's actual GME costs

incurred in those years.[15] The Secretary thus proposed reauditing base-year GME costs to ensure that those costs are "an accurate reflection of legitimate GME costs incurred during the * * * base period." 53 Fed. Reg. 36,591 (1988). The Secretary reasoned that "it is very important that inappropriate costs not be included in the base-period amount." *Ibid.* The Secretary therefore adopted the reaudit rule so that the "average amount recognized as reasonable" for the base year does not include improperly classified or nonallowable costs that would be perpetuated as overpayments in future reimbursements to hospitals. See *id.* at 36,591-36,592; 54 Fed. Reg. 40,301 (1989).

Further, since the Secretary reasonably found it "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely," 54 Fed. Reg. 40,301 (1989), it was reasonable for the Secretary to adopt an approach that would minimize the chance of carrying forward past errors. That interpretation clearly furthers the purpose of the GME Amendment to "*limit payments* to hospitals for their direct costs of approved medical education activities"

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[15] Although Congress has made minor adjustments to the GME Amendment, it has left unchanged its basic methodology of reimbursing GME costs based on the reasonable costs incurred by the provider in the base year. See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13563(a) (updating per-resident amounts), § 13563(b) (amending definition of initial residency period), § 13563(d) (requiring adjustments to base-year GME costs for certain hospitals that did not pay Federal Insurance Contribution Act (FICA) taxes during the base year), 107 Stat. 605-606; see also Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4623 (revising method for counting residents), § 4627 (addressing counting of residents in combined residency programs), 111 Stat. 477-478, 483.

after the effective date of the GME Amendment. H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 482 (1985) (emphasis added). See *Tulane*, Pet. App. 51a ("The agency's belief that Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursements to health care providers can hardly be deemed unreasonable or inconsistent with the congressional purpose of erecting a new and more accurate reimbursement methodology."). By contrast, petitioner's view perpetuates the payment of misclassified and nonallowable costs and would frustrate the purpose of the GME Amendment to limit reimbursement to "reasonable" base-year GME costs.

The Secretary's approach utilizes data and legal principles from the base year, but subject to a readuit of those data to determine whether the applicable legal principles were properly applied. That approach is consistent with the intent of the conferees of the 1986 Act that "[h]ospital-specific approved FTE resident amounts will be determined based on data on direct graduate medical education (GME) costs and numbers of interns and residents, from hospital cost reporting periods beginning in fiscal year 1984." H.R. Conf. Rep. No. 453, *supra*, at 484. Thus, the Secretary's construction of the GME Amendment as reflected in the reaudit rule "closely fits 'the design of the statute as a whole and . . . its object and policy.'" *Good Samaritan Hospital*, 508 U.S. at 418 (quoting *Crandon* v. *United States*, 494 U.S. 152, 158 (1990)).

Contrary to petitioner's suggestion (Br. 40-41), the Secretary had reason to believe that providers' base-year GME reimbursements reflected significant overpayments. The Secretary was particularly concerned

that, "in the past, there have been some questionable [misclassified and nonallowable] costs erroneously reimbursed through the direct medical education pass through." 53 Fed. Reg. 36,591 (1988).[16] For instance, the Secretary noted "several situations * * * in which physicians' costs incurred for activities unrelated to GME, malpractice costs, and medical library costs have been misclassified as GME costs or excessive administrative and general service costs were allocated to the GME cost center." 54 Fed. Reg. 40,300 (1989). The Secretary further explained that "GME costs were not given sufficient scrutiny at the time because of the many changes that were taking place in Medicare generally," including the fact that the GME base period was also the first cost-reporting period under the new PPS methodology. *Id.* at 40,301. Moreover, the GME Amendment introduced a new statutory concept of per-resident GME costs, which caused the Secretary "to examine GME costs that have been reimbursed in the past and to question the

[16] The Secretary explained (1) that misclassified costs are "those costs that were treated as allowable GME costs but that if properly classified would be considered allowable operating costs, such as physicians' compensation costs for services to the hospital that are not specifically and directly related to approved educational activities"; and (2) that examples of nonallowable costs include "the costs of a medical school related to a hospital by common ownership or control * * * that are not directly and specifically related to patient care furnished in the hospital, and physician compensation costs that a hospital claims with respect to services furnished to individual patients that should be paid on a Part B reasonable charge basis." 53 Fed. Reg. 36,591-36,592 (1988).

significant variation in costs that have been allowed." 53 Fed. Reg. 36,593 (1988).[17]

Indeed, the application of the reaudit rule to petitioner aptly illustrates that the Secretary was correct in the belief that hospitals had received excessive payments for GME costs in the base year, and that a reaudit was necessary to correct those errors for purposes of implementing the new payment methodology for future years. Petitioner's original NPR for the 1984 cost year reflected GME costs of $9,892,644. The reaudit revealed that only $5,916,868 of that amount should be recognized as reasonable under the cost-reimbursement standards applicable in 1984. See note 6, *supra*. Thus, the reaudit showed that $3,975,776—approximately 40%—of petitioner's GME reimbursement for the base year had been misclassified or nonallowable. It was clearly rational for the Secretary to construe the GME Amendment to permit a reaudit of costs paid to hospitals such as petitioner to prevent them from receiving unreasonable and profligate payments in the indefinite future.

Petitioner's response (Br. 40-42) to the fact that many hospitals received excessive GME costs in the base year is that the Secretary should have gotten it right the first time, or acted more quickly in promul-

[17] Petitioner is correct in noting (Br. 42 n.17) that the range in base-year per-resident amounts identified by the Secretary, which ranged "from below $10,000 to over $100,000 per resident," may have been due to many factors, including different billing practices. See 53 Fed. Reg. 36,593 (1988). At the time the Secretary proposed the reaudit rule, however, the Secretary reasonably "believe[d], based on situations that have been brought to [HHS's] attention, that misclassification of costs and questionable physician allocation agreements [we]re contributing factors" to the vast discrepancies in per-resident amounts. *Ibid.*

gating the reaudit rule so that the reaudits could have taken place within the three-year reopening period under 42 C.F.R. 405.1885(a). Petitioner believes that the failure to have acted more quickly after enactment of the GME Amendment in April 1986 requires that uncontroverted errors in 1984 reimbursements be perpetuated in future years. Neither the Secretary's delay nor the initial failure to correct errors, however, justifies a reading of the Amendment that would prevent the Secretary from remedying that problem in the future by declining to carry forward impermissible and unreasonable costs.

In any event, the three-year time period between enactment of the GME Amendment and the promulgation of the final GME regulation "was not an unreasonable period for developing, proposing, permitting comment, and finalizing a regulatory framework for a complex statutory scheme." *Tulane*, Pet. App. 51a-52a. As petitioner acknowledges (Br. 23-26 & n.7), the GME Amendment includes a number of provisions that made it necessary for the Secretary to develop new and complex regulations. Thus, the Secretary's regulations implementing the GME Amendment, including the reaudit rule, required extensive analysis. See 53 Fed. Reg. 36,589-36,608 (1988). The Secretary's final regulations, which differed in several respects from the proposed regulations, were the product of the Secretary's careful consideration of the statutory provisions and the issues raised during the rulemaking proceeding. See 54 Fed. Reg. 40,286-40,319 (1989). Accordingly, the Secretary's delay in implementing the GME Amendment does not render the Secretary's construction unreasonable.

2. *The 1990 amendments to the Act that phased in recoupments under the Secretary's GME regulation reinforce the validity of the Secretary's approach*

Congress has, by statute, specifically recognized the Secretary's implementation of the GME Amendment and, far from disapproving that implementation, has instead chosen only to mitigate its financial impact. In the Omnibus Budget Reconciliation Act of 1990 (OBRA), Pub. L. No. 101-508, § 4004(a)(1), 104 Stat. 1388-39 (42 U.S.C. 1395ww note), Congress provided that the Secretary was prohibited, until October 1, 1991, from recovering GME overpayments accrued during cost-reporting years 1985 through 1991 resulting from the new payment methodology of the GME Amendment. The OBRA also limited the Secretary's recovery of those accrued overpayments to 25% of the amount of the overpayments in each of the succeeding four fiscal years. § 4004(a)(2), 104 Stat. 1388-39.

Petitioner contends (Br. 34-35 n.16) that the 1990 legislation does not reflect approval of the Secretary's policy as reflected in the reaudit rule because Congress did not refer to that policy and because the reaudits had not yet been completed by the time Congress enacted OBRA. The Secretary's reaudit rule, however, was promulgated more than a year before the 1990 legislation was enacted, and the legislative history makes clear that Congress was fully aware of the Secretary's implementation of the GME Amendment. The House Report on the

bill in which the GME recoupment limitation originated explained:

> *Section 3102. Hospital Physician Education Recoupment*
>
> *Present Law.*—The Consolidated Omnibus Reconciliation Act (COBRA) limited payment for the direct costs of graduate medical education to an average amount per full time equivalent resident physician updated by the Consumer Price Index. In order to determine the average per resident amount, the Secretary has directed fiscal intermediaries to conduct audits of hospitals to assure that the amount of cost reported is accurate. Some of the audits have identified overpayments to hospitals for graduate costs.
>
> *Proposal.*—The Department would be prohibited from making any recoupments relating to GME in fiscal year 1991. The recoupments would then be made over a four year period, with one-quarter of the amount due from each institution payable in each of the four fiscal years beginning with 1992.
>
> *Effective Date.* — October 1, 1990.

H.R. Rep. No. 899, 101st Cong., 2d Sess. Pt. 1, at 138 (1990).[18] The Conference Report similarly stated:

> The conferees note that the Secretary has recently begun to implement the graduate medical education policy enacted in COBRA 85. The conferees expect the Secretary to recoup overpayments identified as a result of implementing this policy over a four year period, after a one year delay. The Secretary may not recoup more than 25 percent of the total amount of such overpayments from a hospital during each of four fiscal years. Nothing in this provision should be construed to require the Secretary to continue to make such overpayments to such hospitals after the initial identification of such an overpayment.

[18] Section 3102 was part of H.R. 5828, 101st Cong., 2d Sess. (1990), the language of which was added as a floor amendment in the House to H.R. 5835, 101st Cong., 2d Sess. (1990), the bill that was ultimately enacted as OBRA 1990. See 136 Cong. Rec. H10,297, H10,323 (daily ed. Oct. 16, 1990).

H.R. Conf. Rep. No. 964, 101st Cong., 2d Sess. 719 (1990). Congress therefore plainly intended that the Secretary was not required to continue making "overpayments" in future years where an audit had disclosed errors in the base year.

3. *The Secretary's approach is fair and consistent with other reimbursement principles*

a. Petitioner contends (Br. 22-23, 35-40) that the Secretary's reaudit rule conflicts with principles of issue preclusion and fundamental fairness because the reaudits "set aside" (Br. 35, 36) cost determinations for the base year that have become final under the Secretary regulations. See 42 C.F.R. 405.1807, 405.1885(a). That contention, however, overlooks the fact that the reaudits authorized by the Secretary's GME regulation may not be used to recoup erroneous reimbursements for GME costs in any cost-reporting period that is administratively final. See 42 C.F.R. 413.86(e)(1)(iii). The reaudit rule therefore does not upset a final determination with respect to any closed cost-reporting year. Because the Secretary is not attempting to recover payments from administratively settled years, there is nothing in the Secretary's other regulations that prohibits the Secretary from redetermining reasonable GME costs in the base year

for other purposes. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 17 ("Th[e] readjusted number does not affect past reimbursements, for those reimbursements are 'final.' Rather, the corrected number will only be applied in cost reporting years still subject to reopening. * * * This does not violate principles of issue preclusion.").[19]

Similarly, it is plainly rational for the Secretary to prevent hospitals such as petitioner from receiving overpayments in subsequent cost years and in cost years still subject to reopening under Section 405.1885(a). Hospitals certainly have no cognizable expectation with respect to future payments or payments still subject to reopening under the Secretary's regulations.[20] In other words, even if petitioner

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[19] Petitioner's issue-preclusion argument is further undermined where, as here, reimbursement of GME costs in the base year was based on an intermediary's determination in an NPR, without a hearing before the PRRB on the reasonableness of the costs. In those circumstances, the issue of the reasonableness of base-year GME costs would not have been actually litigated in a proceeding of sufficient adversariness and formality to trigger general principles of issue preclusion. See Restatement (Second) of Judgments § 27 & cmt. e, § 28(5) & cmts. c, i, § 83 (1982); cf. *Thomas Jefferson University*, 512 U.S. at 517 (declining to bind the Secretary to a cost determination previously made by an intermediary).

[20] Petitioner contends (Br. 39-40) that "[t]here is a fundamental inconsistency" between the Secretary's reaudit rule and instances in which the Secretary has decided to apply judicial decisions on a prospective basis and to all pending administrative challenges, but not to settled cost reports. See HCFA Ruling 89-1, Medicare and Medicaid Guide (CCH) ¶ 37,614 (1989); HCFA Ruling 97-2, Medicare and Medicaid Guide (CCH) ¶ 45,105 (1997). That argument is without merit. In cases in which the law has changed by judicial decision, the Secretary reasonably has declined to accord retroactive relief

were correct in suggesting (Br. 37) that the three-year reopening period prescribed by Section 405.1885(a) "is the functional equivalent of a statute of limitations," the reaudit regulation neither extends that period nor alters hospitals' legitimate expectations.

This case illustrates the fact that the reaudit rule does not upset providers' settled expectations. Although the 1991 reaudit of petitioner's base-year GME costs demonstrated that petitioner received an excess reimbursement of $3,975,776 due to errors in the original cost report and NPR, the reaudit rule prohibits the Secretary from recouping that amount because more than three years have passed since the

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when the law applicable at the time of the intermediary's decision comported with the Secretary's construction of the Medicare Act, which the provider never challenged on direct administrative appeal. See 42 C.F.R. 405.1885(b) (providing that settled cost reports will be reopened within the three-year period when the Health Care Financing Administration (HCFA) notifies the intermediary that its prior determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]"); cf. *Reynoldsville Casket Co.* v. *Hyde*, 514 U.S. 749, 758 (1995) ("New legal principles, even when applied retroactively, do not apply to cases already closed."); *ICC* v. *Brotherhood of Locomotive Engineers*, 482 U.S. 270, 277-278 (1987) (failure of ICC to reopen proceeding as permitted by 49 U.S.C. 10327(g) because of substantially changed circumstances or new evidence is reviewable only for abuse of discretion). When the GME Amendment was passed in 1986, and until the Secretary issued the GME regulation in 1989, however, hospitals continued to be reimbursed based on their reasonable costs actually incurred. Those payments for GME costs necessarily were conditional, because they were inconsistent with the GME payment methodology imposed by the GME Amendment. Thus, providers could have had no legitimate settled expectation as to payments that were made during that period and that were subject to the Secretary's three-year reopening rule.

original determination. Thus, to the extent that petitioner expected its reimbursable base-year GME costs to be "final and binding" under Section 405.1807 on the date that the three-year period expired under Section 405.1885(a), that expectation has been fully realized. By contrast, petitioner has no legitimate expectation that base-year errors resulting in overpayments will be carried forward into the indefinite future. The reaudit rule does nothing more than prevent such abuse from occurring.

b. The reaudit rule is not invalid, as petitioner suggests (Br. 22, 27, 29, 36), because the reaudits occurred in 1990 and 1991, while hospitals were required to retain certain physician compensation allocation records relating to the 1984 base year for "at least four years after the end of [such] reporting period." 42 C.F.R. 405.481(g)(3) (1985). Before hospitals were permitted by regulation to destroy those records, the GME Amendment, enacted on April 7, 1986, put hospitals on notice that the new GME payment methodology would relate to the 1984 cost-reporting year; at the latest, the Secretary's proposed rule, issued on September 21, 1988, clearly notified hospitals of the Secretary's intention to reaudit base-year costs. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 13. Moreover, because some hospitals nonetheless had discarded records relating to physician cost and time allocation due to the passage of time, the Secretary responded with "an equitable solution" that permitted hospitals, during the reaudit, "to furnish documentation from cost reporting periods subsequent to the base period in support of the allocation of physician compensation costs in the GME base period." See 55

Fed. Reg. 35,990, 36,063 (1990). That flexible approach hardly can be deemed unreasonable.[21]

In any event, petitioner's speculation about particular matters of audit methodology does not warrant invalidating the Secretary's regulation on its face. The regulation permitted providers, including petitioner, to challenge the application of specific auditing principles in individual cases. See 42 C.F.R. 413.86(e)(1) (v). Hospitals dissatisfied with the Secretary's determination were permitted to seek judicial review of that determination. 42 U.S.C. 1395*oo*(f)(1); see, *e.g.*, *Good Samaritan Hospital* v. *Shalala*, 873 F. Supp. 1083 (S.D. Ohio 1994). Thus, the Secretary's regulation reasonably permits an avenue of redress for hospitals that may be prejudiced by the reaudit.[22]

c. Petitioner argues (Br. 43) that the Secretary's reaudit rule produces "inconsistent determinations" for base-year GME costs because the reaudit rule may produce a determination of a hospital's base-year GME costs that differs from the original audit. There is nothing irrational, however, about the fact that the reaudit rule produces a baseline amount of GME costs for future years that corrects for past mistakes by excluding unreasonable costs originally reimbursed by the Secretary. Moreover, the difference between

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[21] Even petitioner availed itself of the Secretary's "equitable solution." Because petitioner did not, even as an initial matter, maintain physician time records in the base year that reflected physician time for teaching medical students, it presented to the PRRB time studies it conducted in 1989 and 1990 to demonstrate the propriety of its allocation of GME costs for 1984. See Admin. Rec. 21-29.

[22] Because petitioner withdrew or settled all of its administrative challenges to the reaudit of its base-year GME costs, see note 6, *supra*, it does not contend that it has been prejudiced by the passage of time.

the amount yielded by the reaudit and the amount yielded by the original audit results from the different statutory commands and purposes at issue. At the time of the original audit, Congress instructed the Secretary to reimburse reasonable GME costs "actually incurred" in each year, subject to limitations of reasonableness. 42 U.S.C. 1395x(v)(1)(A). The annual determinations of GME costs in those prior years had no bearing on subsequent payments. The GME Amendment, however, instructed the Secretary to determine base-year GME costs that would affect payments for all cost periods beginning on or after July 1, 1985. 42 U.S.C. 1395ww(h). For that reason, the Secretary reasonably construed the GME Amendment as permitting reexamination of base-year GME costs to ensure that those costs were in fact reasonable for purposes of subsequent payments. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 18 (finding that "two different, but equally 'allowable,' determinations of a hospital's base year GME costs is reasonable in light of the dramatic shift in cost reimbursement methodology rendered by the GME amendments").

d. Petitioner argues (Br. 43-44) that the reaudit regulation conflicts with cost classifications established under the PPS system for other hospital costs. Specifically, petitioner objects (Br. 44) that the regulation "retroactively repealed the consistency rule" set forth in 42 C.F.R. 412.113(b)(3). The Secretary's GME regulation, however, in fact conforms to that rule.

As noted above (see page 4, *supra*), the PPS reimbursement system for hospital inpatient operating costs took effect at the beginning of fiscal year 1984, while GME costs continued to be reimbursed on a

reasonable-cost basis until enactment of the GME Amendment in 1986. 42 U.S.C. 1395ww(a)(4), (d)(1)(A) and (h)(2). During the PPS four-year transition period, a progressively declining portion of the reimbursement was based on a hospital-specific rate derived from the hospital's actual costs in a given base year, and a gradually increasing portion was based on a federal rate reflecting regional and national standardized amounts. See 42 U.S.C. 1395ww(d)(1)(C). To prevent hospitals from obtaining double reimbursement for the same item of cost during the transition period, *i.e.*, by classifying an item as an operating cost in the PPS base year of 1983 but reclassifying that item as a GME cost in the subsequent transition years, the Secretary adopted the "consistency rule," 42 C.F.R. 412.113(b)(3). Under that rule, GME costs "must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate." *Ibid.* When the Secretary proposed to reaudit base-year GME costs to implement the GME Amendment, the Secretary realized that previously claimed GME costs might be reclassified as operating costs. The Secretary therefore provided in the reaudit regulation that a hospital could request an upward adjustment in its PPS hospital-specific rate if the reaudit resulted in a reclassification of certain GME costs as operating costs. 42 C.F.R. 413.86(j)(1). See note 4, *supra*.[23] At

[23] The reaudit rule is not unreasonable because, as petitioner suggests (Br. 45), some hospitals may not have been able to obtain an increase in the PPS hospital-specific rate because they lacked adequate documentation to demonstrate that a rate increase was warranted or because the reopening period under Section 405.1885(a) already had expired. Many hospitals

the same time, the Secretary amended the consistency rule to reflect the relief being provided to hospitals under the reaudit rule. 54 Fed. Reg. 40,315 (1989) ("Except as provided in 42 C.F.R. 413.86[j] * * *, the costs of medical education must be

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sought and received a higher PPS hospital-specific rate as a result of the Secretary's actions. In the example cited by petitioner (Br. 45), *Harrisburg Hospital* v. *Blue Cross and Blue Shield Association*, Medicare and Medicaid Guide (CCH) ¶ 44,419 (1996), which involved a hospital's attempt to adjust the PPS rate so that more GME costs could be included in the GME base year (see 42 C.F.R. 413.86(j)(2)), the Administrator of HCFA denied the hospital a rate adjustment, not because the hospital discarded relevant records or the reopening period had expired, but because the hospital originally did not consider later-disputed malpractice premium costs to be related to GME and apparently, as a consequence, failed to maintain documents relating to those costs during the GME base year, despite regulations requiring such documentation. See *Harrisburg Hospital*, ¶ 44,419, at 49,418 (citing 42 C.F.R. 413.20, 413.24). Indeed, the Medicare Act generally forbids payment unless the provider "has furnished such information as the Secretary may request in order to determine the amounts due such provider." 42 U.S.C. 1395g(a).

Similarly, petitioner is incorrect in suggesting (Br. 45) that the Secretary acted unreasonably in not adjusting the PPS federal rate to reflect reclassification of costs from education to operating. As the Secretary explained in issuing the reaudit rule, "it would be inappropriate to change all hospitals' prospective payments retroactively to take account of changes to a subset of teaching hospitals' costs. The prospective payment system * * * was designed to set payments in advance, and payment rates were established based on the best data available at the time." 54 Fed. Reg. 40,301 (1989). Moreover, because the federal rate was calculated based on data from the 1981 cost year (42 U.S.C. 1395ww(d)(2)(A); 48 Fed. Reg. 39,763-39,764 (1983)), it is purely speculative whether those costs overreported or underreported GME costs relative to GME costs reported in the GME base year of 1984.

determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate.").

Petitioner does not contend that the Secretary lacked authority to modify the consistency rule for the benefit of hospitals, and it likewise does not contend that the consistency rule prevents the Secretary from rectifying past errors in cost classifications. See *Carle Found. Hospital* v. *Shalala*, 57 F.3d 597, 601 (7th Cir. 1995) (requirement of consistent treatment of costs prevents abuses by Medicare providers and does not restrain the Secretary from "reclassification * * * to achieve the legally mandatory treatment" of costs); *Good Samaritan Hospital* v. *Shalala*, 873 F. Supp. at 1089 (holding that the Secretary "could reasonably conclude that the consistency rule did not preclude the reclassification * * * of erroneously classified GME costs for base years falling within the ambit of [Section] 413.86"). In any event, because the purpose and effect of the Secretary's actions is to *maintain* consistency in the treatment of costs, the Secretary's conduct clearly was reasonable. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 18.

II. THE REAUDIT REGULATION IS NOT AN INVALID RETROACTIVE RULE

Petitioner argues (Br. 46-50) that the GME reaudit regulation is an invalid retroactive rule under this Court's decisions in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988), and *Landgraf* v. *USI Film Products*, 511 U.S. 244 (1994). The intermediary's reaudit of the base year, however, does not introduce any element of retroactivity into the implementation of the GME Amendment. It is therefore not surprising that every court of appeals

to have considered petitioner's contention has correctly rejected it. Pet. App. 3a (*St. Paul-Ramsey*), 25a-26a (*Toledo*), 52a-54a (*Tulane*).

Congress expressly provided the Secretary with authority to issue rules having a retroactive effect, because it made the GME Amendment (which was enacted on April 7, 1986) applicable to cost-reporting periods beginning on or after July 1, 1985. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, Tit. IX, § 9202(b), 100 Stat. 175. Thus, the GME Amendment retroactively changed the rules for reimbursement of GME services that had already been rendered prior to the Amendment's effective date. Indeed, petitioner concedes (Br. 47), as it must, that "there is some retroactivity inherent" in the GME Amendment.

The Secretary's reaudit regulation does not have that sort of retroactive effect on the reimbursement made for GME services actually rendered in the base year. It permits a reexamination of 1984 GME costs *solely* for the purpose of calculating reimbursement for cost-reporting periods beginning on or after July 1, 1985, and its effect on reimbursements in those subsequent years is subject to the limitation on reopening contained in the Secretary's own reopening regulation, 42 C.F.R. 405.1885(a). Accordingly, as the D.C. Circuit explained in *Tulane*, the reaudit rule "is not an exercise in retroactive rulemaking" because the reaudit "carries no impact for actual 1984 reimbursements and will be used only to calculate future reimbursements." Pet. App. 52a. "Rather than altering 1984 reimbursements, HHS's regulations simply permit the Secretary to use reaudited versions of those past figures for the purpose of determining reimbursements in succeeding years." *Id.* at 54a.

The reaudit rule does not affect or impair a hospital's existing right to retain reimbursements received prior to July 1, 1985, because the reaudit figures are not used to recoup reimbursement for any cost-reporting year for which the three-year reopening period has elapsed. 54 Fed. Reg. 40,302 (1989); 42 C.F.R. 413.86(e)(1)(iii). Thus, the reaudit rule does not "impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed." *Landgraf*, 511 U.S. at 280.

This Court repeatedly has made clear that "a statute 'is not made retroactive merely because it draws upon antecedent facts for its operation.'" *Landgraf*, 511 U.S. at 270 n.24 (quoting *Cox* v. *Hart*, 260 U.S. 427, 435 (1922)); see also *Reynolds* v. *United States*, 292 U.S. 443, 449 (1934) ("A statute is not rendered retroactive merely because the facts * * * upon which its subsequent action depends * * * are drawn from a time antecedent to the enactment."). Here, the determination of amounts due providers for GME expenses incurred on or after July 1, 1985, depends on antecedent facts (the reasonable amount, as currently determined, of GME expenses for the 1984 base period). Because a reaudit of the base period involves only a determination of past facts that operates with prospective effect, it does not effect a retroactive change. See *Tulane*, Pet. App. 54a ("within the limited statutory retroactivity, the Secretary's reauditing regulations add nothing further that is retroactive," because "the regulations contemplate only the use of past information for subsequent decisionmaking").[24]

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[24] Contrary to petitioner's contention (Br. 49-50), the reaudit rule is fully consistent with this Court's observation in

Petitioner also asserts that the reaudit rule violates the principle that "the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place." Br. 48 (quoting *Landgraf*, 511 U.S. at 265). In promulgating the reaudit rule, however, the Secretary made clear that the reaudits would apply only those cost principles that were in effect at the time the costs were incurred. See 54 Fed. Reg. 40,301 (1989) ("[N]o new reimbursement principles will be applied * * *. Rather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied."); see also *Toledo*, Pet. App. 25a-26a ("While the reaudit regulation does require a determination based upon events occurring in the base year, it does not change the standards under which the base year costs are to be determined."). The reaudit rule therefore does not retroactively apply new legal standards to petitioner's past conduct.[25]

Hughes Aircraft Co. v. *United States*, 117 S. Ct. 1871, 1878 (1997), that "extending a statute of limitations after the preexisting period of limitations has expired impermissibly revives a moribund cause of action." As the Court in that case explained, such an extension would increase a party's liability by "creat[ing] a new cause of action." *Ibid.* Unlike a law that retroactively extends a limitations period, however, the reaudit rule does not create a new claim against hospitals or increase their liability with respect to prior conduct. Thus, petitioner is wrong in contending (Br. 47) that the reaudit rule "imposes a significant *new* burden on 1984 conduct."

[25] In contrast, the Secretary's regulation at issue in *Bowen* attempted to provide for recoupment under a new substantive standard of sums previously paid to hospitals. 488 U.S. at 207.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

REPLY BRIEF FOR THE PETITIONER

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REPLY BRIEF FOR THE PETITIONER

INTRODUCTION

The provision at issue states in plain and simple terms that "[t]he Secretary shall determine [for a 1984 base year] the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). Read in common parlance and in light of the Act as a whole, similar provisions within it, and the long-standing administrative scheme established under it, the provision is clear and has only one possible meaning: The Secretary must "determine" the pertinent "average" based on the "amount recognized as reasonable" under the established process for determining such costs.

To sustain her alternative construction—under which the Secretary purportedly is authorized to retroactively dismantle the preexisting regulatory regime, reopen closed audit years, and subject providers to reaudits and base

year cost determinations for periods with respect to which critical documentation had been discarded in accordance with the regulatory scheme in effect at the time the statute was enacted—the Secretary attempts to manufacture ambiguity in the plain and simple terms of § 1395ww(h)(2)(A) (Br. 19-21), repeatedly seeks refuge in the alleged absence of an express prohibition of an extraordinary procedure (Br. 19 n.8, 21, 26, 29), and attempts to gain favor with the Court by suggesting that her interpretation was necessary to serve an end (accuracy) that the Secretary herself acknowledges Congress did not even have in mind when it enacted the statute (Br. 27). As explained below, none of these efforts can overcome the clear command of § 1395ww(h)(2)(A), to which both the Secretary and this Court are required to give effect under *Chevron* and the fundamental principles of separation of powers embodied in that decision. Moreover, the regulation issued by the Secretary to implement her construction, which retroactively revoked the reopening and record retention standards in effect in the base year and departed from the substantive standards then in effect, contravenes the bar against retroactive rulemaking established by this Court's precedents.

ARGUMENT

I. THE SECRETARY'S REAUDIT REGULATION VIOLATES THE PLAIN MEANING AND CLEAR INTENT OF 42 U.S.C. § 1395ww(h)(2)(A).

1. The Secretary misstates the question in this case.[1] The question is not whether the Secretary could reaudit 1984 graduate medical education ("GME") costs. She clearly could, so long as she did so within the reopening and record retention periods applicable to 1984 and applied the reimbursement standards in effect in 1984, including the consistency rule.

[1] The question presented by the Secretary is whether she "reasonably construed 42 U.S.C. 1395ww(h) to authorize the reaudit of a hospital's GME costs incurred in the base year for the purpose of determining the reimbursement due in subsequent years."

The question here is whether the Secretary could reaudit 1984 *after* expiration of the applicable reopening and record retention periods using new reimbursement standards not in effect in 1984. The Secretary concedes that she could not have conducted such a reaudit to amend the amount recognized as reasonable in the notice of program reimbursement ("NPR") for 1984 itself (Br. 7, 8-9 n.5, 39). She argues, however, that she was entitled to conduct an untimely audit to determine the average 1984 amount per resident under the GME legislation and to use as the numerator an amount that differs from the actual amount recognized as reasonable in the final and binding NPR for 1984. The Secretary's position conflicts with 42 U.S.C. §1395ww(h)(2)(A), which requires her to determine the average based upon the "amount recognized as reasonable under this subchapter" for 1984. The Secretary failed to use that amount and thus violated Congress' clear command.

2. The Secretary struggles to create ambiguity but her efforts cannot obscure the fact that § 1395ww(h)(2)(A) is simple and straightforward. The statute simply authorizes the Secretary to determine an "average." *Toledo Hosp. v. Shalala*, 104 F.3d 791 (6th Cir. 1997), *petition for cert. filed*, No. 96-2046, Pet. App. 29a-30a. It does not authorize the Secretary to redetermine the numerator and then determine the average.[2]

The Secretary argues (Br. 17) that the GME statute permits her to determine a new amount of GME cost (different from that actually recognized for 1984) so long as she applies the reasonable cost payment principles in effect in 1984. As discussed in § II, the Secretary has,

[2] The Secretary reads words into the GME statute that are not there. She asserts (Br. 44), for instance, that the "GME Amendment . . . instructed the Secretary to determine base-year GME costs that would affect payments for all cost periods beginning on or after July 1, 1985." In fact, the GME legislation does not "instruct" the Secretary to "determine base-year GME costs" at all. It simply mandated that the Secretary determine an average. *Toledo*, Pet. App. 29a-30a.

in fact, departed from the reasonable cost payment principles in effect in 1984 in her reaudits. Further, the statute provides no basis for the Secretary's attempt to detach 1984 reasonable cost reimbursement standards from the 1984 administrative scheme used to establish the amount recognized as reasonable under those standards. The words "under this subchapter" do not just follow the word "reasonable," as the Secretary suggests (Br. 21). They follow a phrase that begins with the word "amount" —"amount recognized as reasonable." 42 U.S.C. § 1395ww(h)(2)(A).

It is well-established that Congress is presumed to be aware of the existing statutory and regulatory regime governing the area in which it legislates. Pet. Br. 21. That principle (entirely ignored in the Secretary's brief) is particularly forceful here. When Congress used the phrase "amount recognized as reasonable under this subchapter" in the 1986 legislation, there was an administrative scheme, which had been in effect under the Medicare subchapter for nearly 20 years (Pet. Br. 6, 19-20; Br. 2-4), that would recognize an amount as reasonable for 1984.

Moreover, Congress had twice within the previous four years used a nearly identical phrase—"recognized under this subchapter"—in other subsections of the same section of the Medicare statute (§ 1395ww) that likewise used a base year amount to establish prospective payment limits for subsequent periods. Pet. Br. 30-32 (discussing 42 U.S.C. § 1395ww(a)(1)(C), (b)(3)(A)(i), (d)(1)(A)(i)(I), and (d)(1)(A)(ii)(I)). Inasmuch as the Secretary had in each of those instances acted with dispatch to recognize the base year amounts within the confines of the existing administrative scheme for recognizing costs as reasonable (Pet. Br. 30-32; Br. 28), Congress would not have used virtually identical terms in subsection 1395ww(h)(2)(A) if it had intended to grant the Secretary unbridled discretion to disregard the established administrative scheme in implementing that statute.

The simple fact is that in the GME legislation Congress did not confer on the Secretary *any* authority to determine a hospital's base year GME costs. Its failure to do so was not an oversight. The GME legislation reflects careful attention to detail and delegated authority to the Secretary where action by the Secretary was needed. Pet. Br. 23-26. Congress did not confer authority to determine base year GME costs because a long-standing process for determining those costs was already established under the Medicare subchapter, which is why the GME statute refers to the "amount recognized as reasonable *under this subchapter*." (Emphasis added.) Thus, as the Sixth Circuit correctly concluded in *Toledo*, "[w]hen Congress passed the GME amendment in 1986, it knew that there was an administrative scheme in place that would determine the reasonable GME costs for providers for fiscal 1984. . . . It follows that Congress must have contemplated that the Secretary would use those administratively determined reasonable costs as the basis for calculating the average GME cost per full-time-equivalent resident." Pet. App. 30a-31a.

3. The reaudit regulation is based on the premise that the Secretary was free, for purposes of the GME legislation, "to 'recognize' [1984 GME] costs at any time in the future and in a manner utterly detached from the established procedural framework." *Toledo*, Pet. App. 30a. That premise conflicts with Congress' command that the GME legislation "shall apply to hospital cost reporting periods beginning on or after July 1, 1985." Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. 99-272, § 9202(b). Congress did not authorize the Secretary to defer implementation of the GME amount per resident payment system.

To the contrary, Congress clearly expressed its intent that the Secretary would determine the average amounts per resident promptly and well within the reopening and record retention periods applicable to 1984. The 1986

COBRA legislation that enacted the GME statute also mandated in § 9202(e) that:

> [t]he Secretary of Health and Human Services *shall report* to [the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives], *not later than December 31, 1987*, on whether section 1886(h) of the Social Security Act [42 U.S.C. § 1395ww(h)] should be revised to provide for greater uniformity *in the approved FTE resident amounts established under paragraph (2) of that section*, and, if so, how such revisions should be implemented.

(Emphasis added.) To comply with that mandate, the Secretary had to "establish" the "approved FTE resident amounts" (*i.e.*, the GME base year average amounts per resident) well before December 31, 1987, a date which preceded expiration of the reopening and record retention periods for 1984 in all cases.[3]

Section 9202(e) of COBRA proves that Congress did *not* intend the Secretary to determine the base year average by using as the numerator a "redetermined" amount of 1984 cost that differs from the actual amount recognized as reasonable for 1984. *See also Methodist Hosps. of Memphis v. Sullivan*, 799 F. Supp. 1210, 1218 (D.D.C. 1992) ("Congress could not have intended that the Secretary interpret 'recognized as reasonable' to mean two amounts for fiscal 1984: one derived from the standard cost reporting and review process following the close of the fiscal year; and a lower amount recalculated once the Secretary realized that the year would become the base-year for subsequent determinations."), *rev'd sub nom. Administrators of Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994). Congress intended that the Secretary establish the amounts per resident before December 31, 1987—

[3] The Secretary failed to comply with Congress' mandate and did not file the required report until March 24, 1992.

at a time when all 1984 years were still within the Medicare reopening and record retention periods.[4]

Thus, viewed from the perspective of April 1986, when COBRA was enacted, the temporal ambiguity that the Secretary now attempts to impose on the statute was non-existent. Congress intended the Secretary to act promptly to implement the new payment system. COBRA, § 9202(b), (e). As the Secretary concedes (Br. 27), Congress had no concerns about the accuracy of the base year audits. Congress expected the Secretary to establish the base year amounts per resident in 1986 or 1987. COBRA, § 9202(e). If the Secretary had acted in accordance with Congress' mandate, she would have had no occasion to audit 1984 after expiration of the applicable reopening and record retention periods or to determine the base year amount per resident by using a 1984 amount

[4] The Secretary asserts (Br. 24) that "under petitioner's theory," she would have been free to reaudit the base year if she had "expressly amend[ed] the reopening regulation to lengthen the reopening period for base-year GME costs solely for purposes of determining the proper amount of reimbursement due in subsequent years under the GME Amendment, without disturbing the amount of reimbursement that the provider already had received for services that were rendered in the base year." In fact, the Secretary could not have done this for at least three reasons. First, the statute requires the Secretary to determine the base year average by using the actual amount recognized as reasonable under the Medicare subchapter for 1984. Thus, the statute does not allow the Secretary to determine the average by using an amount that is different than the amount that was actually recognized as reasonable for 1984. Second, the Secretary cannot *retroactively* amend the reopening and document retention standards in effect in 1984 and retroactively render her final and binding determination of 1984 costs non-final and non-binding, as she did in this case. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213-15 (1988). Third, extending the reopening period would have been inconsistent with Congress' intent that the Secretary implement the new methodology promptly and establish the base year amounts per resident well before December 31, 1987 (a date that in all cases substantially preceded expiration of the reopening and record retention periods for 1984). COBRA, § 9202(b), (e).

that differs from the amount actually recognized as reasonable for 1984. Thus, the Secretary's claimed ambiguity is based not on any uncertainty regarding Congress' intent when COBRA was enacted but on nothing more than the alleged absence of an express prohibition of "an unusual procedure . . . plainly at odds with the result Congress was trying to reach."[8] *Toledo,* Pet. App. 29a.

As discussed in the opening brief (Pet. Br. 42-43), the Secretary's "unusual procedure" would allow a perpetual series of reaudits of 1984. Because the Secretary became dissatisfied with her original audit determinations for 1984, she conducted a reaudit of 1984 in 1991, even though the reopening and record retention periods for 1984 had long since expired. If in 1998 she became dissatisfied with her 1991 reaudit of 1984, the Secretary would, under her logic, be free to reaudit 1984 again in 1998—and again in 2002 and 2004, if she chose. The statutory deadline established by COBRA, § 9202(e) clearly demonstrates that Congress did not intend to sanction such a bizarre result.

4. Perhaps recognizing the patent flaws of her position under 42 U.S.C. § 1395ww(h), the Secretary asserts (Br. 21) that she was entitled to issue the reaudit regulation under her purported "broad authority to promulgate regulations setting forth the methods to determine reasonable costs and the items to be included in reimbursable services." The Secretary's reliance on her general rulemaking authority is misplaced for several reasons.

First, an agency cannot exercise its general rulemaking authority to contradict the will of Congress. Pet. Br. 26

[8] The Secretary continues to anchor her ambiguity claim in the absence of an express prohibition. Br. 19 n.8, 21, 26, 29. As discussed above, the Secretary's position is inconsistent with the intent of the COBRA legislation and, in any event, her approach is ill-suited to discerning Congress' intent under *Chevron* step one. If sanctioned, it would give agencies "virtually limitless hegemony" under the *Chevron* framework. *Railway Labor Executives' Ass'n v. National Mediation Bd.*, 29 F.3d 655, 671 (D.C. Cir. 1994) (en banc), *cert. denied*, 115 S. Ct. 1392 (1995); Pet. Br. 32-34.

n.8. As discussed above, Congress issued a straightforward command for the Secretary to determine an "average" using as the numerator the amount recognized as reasonable under the Medicare subchapter for 1984. The Secretary violated this plain command by using a different number established under a new and untimely administrative process.

Second, the reaudit regulation is not a "reasonable cost" regulation. It is a regulation purportedly issued to implement the GME prospective payment system established by COBRA. As discussed in Pet. Br. at 23-26, the GME statute is carefully crafted and significantly circumscribes the Secretary's authority. Where Congress intended to delegate authority to the Secretary, it did so expressly. *Methodist Hosps. of Memphis,* 799 F. Supp. at 1218. Indeed, the Secretary conceded this when she issued the GME regulation, noting that the statute is "largely self-implementing" and that she therefore had "little discretion in crafting" the regulation. 54 Fed. Reg. 40,314 (1989).

Third, the 1986 legislation refutes the Secretary's assertion of broad authority to legislate under her general rulemaking authority in 42 U.S.C. § 1395x(v)(1). The same section of COBRA that enacted the GME statute also enacted 42 U.S.C. § 1395x(v)(1)(Q), which provides:

> Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical education activities.

COBRA, § 9202(i). Even the Secretary concedes (Br. 17-18) that she was not "explicitly authorized" to conduct a special reaudit of 1984 costs under the GME statute after expiration of the applicable reopening and record retention periods. Moreover, the Secretary's general rulemaking authority would not allow the Secretary to ignore the statutory deadline imposed by COBRA, § 9202(e).

Finally, the Secretary's grants of general rulemaking authority do not confer on her retroactive rulemaking authority. *Georgetown,* 488 U.S. at 213-15. Thus, if the

Secretary, in fact, had the authority to apply new principles to 1984 and to retroactively revoke the reopening and record retention periods applicable to 1984 for purposes of implementing the GME statute, her authority must be found in the GME statute, not in her general grants of rulemaking authority. The Secretary recognized this fact when, at the time she issued the reaudit regulation, she stated that "the agency is not relying on our general grant of rulemaking authority to support retroactive application, but, rather, on a specific congressional enactment [the GME statute]." 54 Fed. Reg. 40,314 (1989).

5. Moving even further afield of Congress' intent in enacting § 1395ww(h)(2)(A), the Secretary asserts (Br. 17-18) that her reaudit of 1984 after expiration of the applicable reopening and document retention periods was necessary to prevent the perpetuation of base year errors for future years. She has, however, never presented any evidence of actual errors [6] or explained why, if there were errors, she could not have corrected them by the deadline mandated in COBRA, § 9202(e), a date within the established three-year reopening period for 1984. Moreover, the Secretary acknowledges (Br. 27) that neither "the text nor the history of the GME Amendment" indicates that *Congress* had any concerns regarding the accuracy of the Secretary's audit determinations.[7] Congress, therefore, could not possibly have intended, when it enacted the GME statute, to authorize the Secretary to conduct untimely reaudits to correct alleged errors in the amounts

[6] During the rulemaking process, the Secretary made only vague references to unidentified "situations" that had been "brought to our attention." 54 Fed. Reg. 40,300 (1989).

[7] The Secretary's concern regarding variations in the amounts per resident from hospital to hospital, 53 Fed. Reg. 36,593 (1988), would have come as no surprise to Congress. As discussed above, when Congress enacted the GME legislation, it directed the Secretary to report, "not later than December 31, 1987, on whether [the GME statute] should be revised to provide for greater uniformity in the approved FTE resident amounts established . . ., and, if so, how such revisions should be implemented." COBRA, § 9202(e).

recognized as reasonable for 1984 because, as the Secretary concedes (Br. 27), Congress had no reason to believe there were errors. As a result, the Secretary's purported "accuracy" concerns are irrelevant to this Court's inquiry under *Chevron* step one. *Toledo*, Pet. App. 32a-33a.

Furthermore, the Secretary ignores the plain fact that subjecting hospitals to a reaudit after expiration of the reopening and record retention periods, at a time when memories have faded, documents have been lost or discarded, and personnel have turned over, increases the likelihood of erroneous base year determinations. The Secretary's premise that untimely audits promote accurate results runs counter to common sense and the well-founded principle that the staleness of evidence, after expiration of a limitations period, forecloses a meaningful search for truth and requires repose.[8] Pet. Br. 37-38. Thus, "the normal policy of a statute of limitations is to close the door—finally, not qualifiedly or conditionally." *Anderson v. Yungkau*, 329 U.S. 482, 486 (1947). Once a limitations period has expired, there is an "irrebuttable presumption" of "prejudice[]." *United States v. Marion*, 404 U.S. 307, 322 (1971).

If the Secretary truly believed there were inaccuracies in the audit determinations for 1984, she had ample time

[8] The Secretary mischaracterizes the nature of the Medicare reopening standard. The Secretary's statement that the "Act itself does not place any limitations on the time in which a reimbursement decision" may be reopened (Br. 3) is true only because, as the Secretary fails to point out, the Act itself does not provide for any reopenings of administrative determinations at all. Instead, the Act characterizes the Secretary's NPR for a year as a "final determination" subject to appeal (without any reference to reopenings). 42 U.S.C. § 1395oo(a)(1)(A)(i). Thus, by allowing for a three-year reopening period (in addition to the statutorily-established appeals process), the Secretary's reopening regulations do not restrict what the Act would otherwise allow, as the Secretary implies. Instead, the Secretary's reopening regulations adopt a very expansive construction of the statute, *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 617-19 (D.C. Cir. 1994), that allowed the Secretary ample time to make any revisions to the 1984 NPRs that she believed to be necessary.

to reopen and revise the 1984 audit determinations through the administrative procedures established under the Medicare subchapter. Once the reopening and document retention periods had expired, she still had an available remedy—she could have informed Congress of the perceived problem and requested further legislation. *Toledo*, Pet. App. 33a.

If the Secretary had done so and if Congress had agreed with the Secretary's concerns, Congress would have been free to take a number of different courses. But, by acting on her own to remedy what she perceived to be a defect in the statute, the Secretary clearly exceeded her authority under the GME legislation. *See* COBRA, § 9202(e); *see also Board of Governors of Fed. Res. Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 374 (1986) ("The statute may be imperfect, but the Board has no power to correct flaws that it perceives in the statute it is empowered to administer. Its rulemaking power is limited to adopting regulations to carry into effect the will of Congress as expressed in the statute").

II. EVEN ASSUMING *ARGUENDO* AN AMBIGUITY IN THE STATUTORY LANGUAGE, THE REAUDIT REGULATION ADOPTS A PATENTLY UNREASONABLE CONSTRUCTION.

Even assuming that the reaudit regulation could pass muster under *Chevron* step one, it would nonetheless fail under *Chevron* step two because it is a patently unreasonable construction of § 1395ww(h)(2)(A).

1. As discussed previously (Pet. Br. 42-43), the Secretary's position would allow perpetual reaudits of 1984. Significantly, the Secretary has never denied that the logic of her position permits this result. Indeed, the Secretary underscores the absurdity of her position, arguing (Br. 39-40, 48) that, even though her reaudit is a reaudit of 1984, the relevant reopening period is the reopening period applicable to each year subject to payment under the GME statute, which would permit application of one determination of 1984 GME costs for 1987, another for 1990, another for 1993, and so on. Under the Secretary's

logic, a teaching hospital would be forever subject to reaudits of 1984, resulting in numerous amounts recognized as reasonable for 1984 and foreclosing the possibility of reaching repose. *Cf. Kennecott Utah Copper Corp. v. United States Dep't of Interior*, 88 F.3d 1191, 1211-13 (D.C. Cir. 1996) (rejecting under *Chevron* step two agency's construction of the word "promulgated" because it unreasonably deferred the date on which the statute of limitations would begin to run).

The Secretary's position stands logic on its head in another respect. The Secretary concedes (Br. 7, 13-14, 39) that once the limitations period expired for 1984, it was improper to reaudit 1984 to amend Medicare payment for 1984, but argues that because 1984 had a significant impact on payment for later years, it was permissible to conduct an untimely reaudit of 1984 to establish payment for later years. Reason dictates the opposite conclusion. The importance of the 1984 cost determination increases, not diminishes, the need to ensure that the determination is made at a time when memories are fresh and records are readily available so that accurate results are obtained.

Moreover, the Secretary's position conflicts with the plain wording of her regulations. The regulations governing the effect of an intermediary determination provide that, unless the determination is timely appealed or timely reopened, the "findings on matters at issue" in the determination, 42 C.F.R. § 405.1885(a), "*shall be* final and binding." 42 C.F.R. § 405.1807 (emphasis added). Those words are unqualified. They do not say that the intermediary's determination shall be final and binding for some purposes but not for others. Thus, as the Sixth Circuit concluded in *Toledo*, "the principle of issue preclusion prevents the Secretary from requiring providers to reestablish the costs that they already proved years ago." Pet. App. 36a.

2. The Secretary has represented in her brief (Br. 7, 14-15, 50) that the reasonable cost reimbursement principles in effect in 1984 were applied during the GME reaudits. In fact, that is not the case. As the Secretary's

regulations reflect, the Secretary revoked the consistency rule in effect in 1984 for purposes of the reaudit.[9] Pet. Br. 10, 43-45. Further, the Secretary's recent decision in *Blessing/St. Mary Group Appeal v. Blue Cross & Blue Shield Ass'n*, [New Developments] Medicare and Medicaid Guide (CCH) ¶ 45,554 (HCFA Adm'r 1997), plainly contradicts her representations to this Court.

In *Blessing*, the Secretary, through her delegate, the Administrator of the Health Care Financing Administration, annouced that the statement in the *Federal Register* preamble that "no new reimbursement principles will be applied during the reaudit" was intended to apply only "[w]ith respect to the documentation necessary to support a hospital's GME base-year costs." *Id.* at 54,786. The Secretary, therefore, concluded that a controlling Seventh Circuit precedent construing the GME reasonable cost regulation in effect during 1984 was inapplicable to the determination of the base year average amounts per resident even for hospitals located in the Seventh Circuit. The Secretary reasoned that the Seventh Circuit decision was inapplicable because it involved:

> cost periods prior to the effective data [sic] of COBRA, and they involved a different method of payment [*i.e.*, reasonable cost] for GME costs. Thus, the Administrator finds that those cases are not pertinent to the issues in this case involving base-year costs to be recognized for determining GME payments under the COBRA GME payment methodology.

[9] The Secretary's assertion (Br. 47) that she maintained consistency by permitting retroactive revisions to the PPS hospital-specific rate is absurd. The Secretary made conforming amendments to the PPS hospital-specific rate only if hospitals followed a restrictive procedure and were able to furnish documentation from 1982, which many quite understandably could not since the record retention period for 1982 had long since expired. Pet. App. 44-45. Moreover, the Secretary allowed no conforming amendments to the federal rate (the principal component of PPS) so that reclassification of costs in the GME reaudit resulted in allowable costs (whether characterized as operating or GME) not being allowed at all. *Id.*

Id. at 54,790 n.61. The *Blessing* decision confirms that the substantive reimbursement principles applied in the reaudits conducted "under the COBRA GME payment methodology" are quite different from the GME reasonable cost standards in effect during the GME base year (1984).

3. The Secretary's argument (Br. 35) that her 1991 reaudit of petitioner's 1984 year proves that "the Secretary was correct in the belief that hospitals had received excessive payments for GME costs in the base year" is circular. The fact that an untimely reaudit produced a lower amount than the timely audit conducted for 1984 is not at all surprising and hardly proves that the untimely reaudit was accurate and the timely audit was erroneous. Indeed, quite the opposite conclusion is required.[10] Appli-

[10] Petitioner was, in fact, very seriously prejudiced by the Secretary's untimely reaudit. Only $364,641 of the $9.9 million allowed as GME in the NPR for 1984 was determined to be nonallowable in the reaudit. Administrative Record 133-165 (adjustments 3-5, 28, 31, 38, 43-45, 47-51, 59, 63 & 91). Those costs were more than offset by $633,151 of costs that the intermediary classified as GME costs in the reaudit but that had not been classified as GME in the NPR. *Id.* (adjustments 10-11, 46, 82-90, & 163). Moreover, according to the audit adjustments, $228,098 (63%) of the $364,641 of costs determined to be nonallowable were disallowed in the reaudit solely because petitioner no longer had audit documentation to support the expense. *Id.* (adjustments 3, 5, 38, 43-45, 47, & 50-51).

The difference between the amount of GME costs recognized as reasonable in the NPR for 1984 and the amount of GME costs used to calculate petitioner's base year amount per resident is attributable solely to the *recharacterization* of GME costs as operating costs for purposes of the reaudit. Most of the difference relates to time reported as administrative time in the physician time studies conducted in 1984 using the time study format recommended by the Secretary. *Id.* (adjustments 92-116). In the original audit, the intermediary determined that the physicians' administrative services were performed in connection with the GME program and thus were allowable as GME costs rather than as operating costs. In the reaudit, the intermediary changed the classification of these expenses from GME costs to operating costs not because it uncovered new evidence demonstrating that the costs should be classified as operating expense, but because petitioner no longer had audit documentation, in a reaudit conducted six to seven years after

cation of the lower cost figure from an untimely audit proves that petitioner is, in fact, being significantly underreimbursed under the GME methodology.[11] *See Marion*, 404 U.S. at 322 (expiration of the limitations period raises an "irrebuttable presumption" of prejudice).

The Secretary's position seems to be that her reaudit figures are more accurate simply because they are lower. In fact, however, the reaudit figures are likely to be much *less* accurate because of the absence of critical documentation. More significant, there is absolutely no indication in the text or legislative history of § 1395ww(h)(2)(A) that Congress intended to penalize providers by subjecting them to reaudits of important base year amounts after the reopening and document retention periods had lapsed.

4. The Secretary erroneously asserts (Br. 42) that hospitals were put on notice by the proposed rule published on September 21, 1988, that the Secretary would reaudit 1984 and thus acted unreasonably in relying on the Secre-

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the base year, showing that the costs related specifically to GME, as opposed to other administrative activities benefitting the hospital generally. In the absence of such documentation, the Secretary simply applied a default rule in favor of characterizing the costs as operating costs rather than as GME costs.

[11] Significantly, the Secretary's original audit determination for 1984 was entirely in line with her determinations for prior years, including the PPS base year. The progression is as follows:

1981—$8,586,635
1982—$8,763,878
1983—$9,619,153.

Audited cost reports accompanying notices of program reimbursement dated September 9, 1983 (1981), March 2, 1984 (1982), and August 26, 1985 (1983). The amount of GME costs allowed in the NPR for 1984 ($9,892,644) was only 2.8% higher than the determination of GME costs for 1983 and only 15.2% higher than the determination of GME costs for 1981—in both cases, the rate of increase was below the rate of inflation in those years. In contrast, the Secretary's reaudit determination for 1984 ($5,916,868), conducted when petitioner's personnel had turned over and records were often no longer available, is an aberration. The amount of the Secretary's reaudit determination for *1984* is only 68.9% of the amount of GME costs that the Secretary recognized as reasonable for *1981*.

tary's reopening and record retention standards. The proposed notice, in fact, nowhere suggested that reaudits would be conducted after the base year was closed. *Cf.* 53 Fed. Reg. 36,592 (1988). Nor did it furnish adequate notice of the burden that the Secretary ultimately imposed on teaching hospitals. *Toledo*, Pet. App. 37a ("brief mention in the Federal Register of the possibility of reaudits . . . cannot be considered notice of the need to retain physician allocation and compensation records"). Further, a proposed notice obviously could not revoke the standards in effect in 1984 or justify the Secretary's failure to compute the base year average using the actual amount recognized as reasonable for 1984, as the statute requires.

5. The Secretary argues (Br. 32-33) that the reaudit was consistent with Congress' purpose to "limit payments to hospitals for their direct costs of approved medical education activities. . . ." H.R. Conf. Rep. 99-453, 99th Cong., 1st Sess. 482 (1985). Resort to the general purposes of legislation is the "last redoubt of losing causes." *Director v. Newport News Shipbuilding & Dry Dock Co.*, 115 S. Ct. 1278, 1288 (1995); *see also Dimension Fin. Corp.*, 474 U.S. at 374 ("Invocation of the 'plain purpose' of legislation at the expense of the terms of the statute itself . . . prevents the effectuation of congressional intent").

The terms of the GME statute specify how Congress intended to "limit payments." Congress did not authorize the Secretary to establish additional, extra-statutory means. To the contrary, Congress provided: "Except as otherwise explicitly authorized, the Secretary is *not authorized* to limit the rate of increase on allowable costs of approved medical education activities."[12] COBRA, § 9202(i) (emphasis added).

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[12] As previously discussed (Pet. Br. 34-35 n.16), the Secretary's reliance on 1990 legislation governing the recoupment of alleged GME overpayments (Br. 37-39) is misplaced. The relevant congressional intent here, of course, is that of the Congress that enacted § 1395ww(h) in 1986, not that of the Congress that enacted the 1990 provision. *See Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 840 (1988); *International Bhd. of Teamsters*

III. THE REAUDIT REGULATION CONSTITUTES AN IMPERMISSIBLE RETROACTIVE CONSTRUCTION OF THE GME STATUTE.

The Secretary's reaudit regulation goes beyond the confined element of retroactivity inherent in § 1395ww(h). Unlike the statute, the reaudit regulation does not simply attach new future consequences to transactions that occurred in 1984. The reaudit regulation requires a new determination of matters at issue with respect to 1984 transactions (*i.e.*, the amount of reasonable GME costs incurred in 1984) after expiration of the period in which findings on matters at issue for the 1984 base year could be reopened and subject to new legal principles not in effect in 1984. The regulation, therefore, "changed the *law* retroactively, a function not performable by rule under the APA" in the absence of express authorization from Congress. *Georgetown*, 488 U.S. at 220 (Scalia, J., concurring) (emphasis in original).

Thus, the Secretary's reliance on the principle that legislation is not retroactive merely because it draws upon antecedent facts for its subsequent operation is entirely

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v. United States, 431 U.S. 321, 354 n.39 (1977). Moreover, the 1990 legislation is fully consistent with petitioner's plain meaning construction of § 1395ww(h)(2)(A). As the Secretary acknowledges (Br. 41 n.20), despite the enactment of the GME legislation, the Secretary continued to apply "reasonable cost" principles to settle 1986-1989 cost reports, rather than use the GME methodology mandated by law. Because, as all agree, hospitals were not entitled to reimbursement under reasonable cost principles for those years, recoupment was required to effectuate the GME legislation, irrespective of the proper resolution of the issue in this case. The 1990 legislation simply protected hospitals from the severe cash flow problems that might otherwise have occurred if the Secretary effected recoupment for all years at one time.

Furthermore, the House Report cited by the Secretary (Br. 38) is not part of the history of the legislation enacted in 1990. The cited report was issued with respect to a bill (H.R. 5828) that was never passed by the House, not with respect to the House bill that led to the enactment of the 1990 legislation. Moreover, the language used in the applicable provision of the unenacted bill was significantly different than the language used in the statute that was enacted.

misplaced. The Secretary's regulation does not draw upon antecedent facts. Rather, the Secretary's calculation of the average base year amount per resident depends upon "antecedent facts . . . *as currently determined*." Br. 49 (emphasis added). Those redetermined "facts" are not "antecedent" to the reaudit regulation. The only "facts" pertaining to petitioner's reasonable GME expenses for the 1984 base year that are "antecedent" to the 1989 reaudit regulation are the "findings on matters at issue" in the NPR for 1984, which, as the Secretary concedes (Br. 8-9 n.5), was final, binding, and no longer subject to reopening prior to the adoption of the reaudit regulation.[18] 42 C.F.R. §§ 405.1807, 405.1885(a).

The Secretary's reaudit regulation extended a limitations period after it expired. Accordingly, it is retroactive, *Hughes Aircraft Co. v. United States*, 117 S. Ct. 1871, 1878 (1997), and is therefore invalid in the absence of a clear statement of Congressional intent to authorize reaudits of 1984 after expiration of the three-year reopening period. *Georgetown*, 488 U.S. at 208. Even the Secretary concedes (Br. 17-18) that the GME legislation includes no such clear statement.

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[18] Thus, the Secretary's bald assertion (Br. 14, 49-50 n.24) that the reaudit regulation does not create a new cause of action against hospitals or increase their liability with respect to 1984 conduct is absurd. The reaudit of the final and binding findings on matters at issue in the NPR for 1984, which is the event giving rise to this action, could not have been performed but for the Secretary's retroactive rescission of both the three-year reopening limitation for 1984 and the record retention period for 1984.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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